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California and Western Medicine

Official Publication of the
CALIFORNIA MEDICAL ASSOCIATION

◆

PRINTED AND EDITED
for the
California Medical Association
Under the direction of the House of Delegates and Council
GEORGE H. KRESS, M.D., *Editor*

◆

VOLUME 50

JANUARY *to* JUNE, 1939

CALIFORNIA MEDICAL ASSOCIATION, FOUR FIFTY SUTTER
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  (a) General.
  (b) Component County Societies.
  (c) Department of Public Relations.
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* * *

Key to Abbreviations in This Index

Or.—Original Article.
C. R.—Case Report.
B. M.—Bedside Medicine.
Ed.—Editorial.
E. C.—Editorial Comment.
C. N.—Clinical Notes.
L. M. H.—Lure of Medical History.
Sup.—Supplement (by month).

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CALIFORNIA
AND
WESTERN MEDICINE

Official Journal of the California Medical Association

FOUR FIFTY SUTTER, ROOM 2004, SAN FRANCISCO

VOLUME 50
NUMBER 1.

JANUARY · 1939

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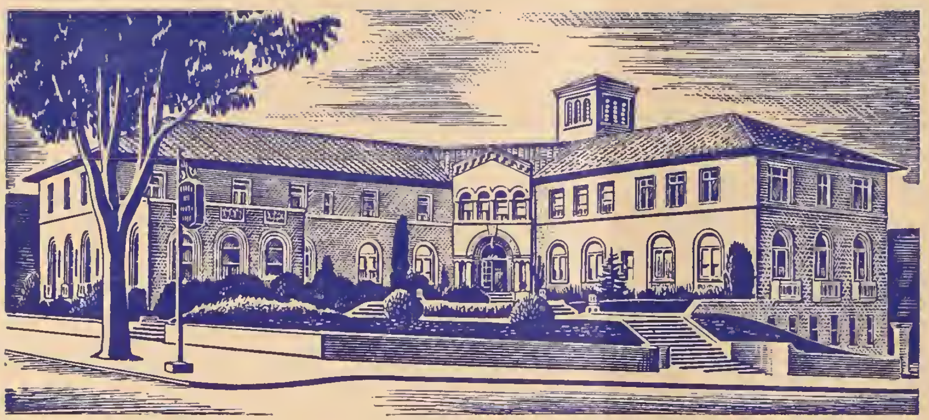
Owned and Published Monthly by the California Medical Association
Copyright, 1939, by the California Medical Association
"Entered as second-class matter at the post office at San Francisco, under the Act of March 3, 1879." Acceptance for mailing at special rate of postage provided for in Section 1103, Act of October 3, 1917, authorized August 10, 1918.



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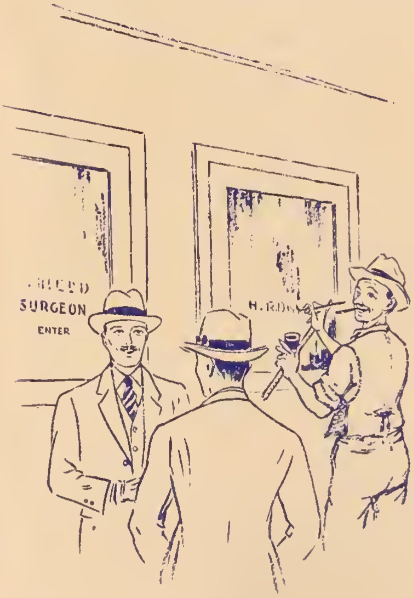

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The Committee on Public Relations consists of the chairmen of the following standing committees and of certain general officers of the Association, all serving ex officio. The chairman of the committee is George G. Reinle, the secretary is George H. Kress. The director of the Department of Public Relations is George H. Kress. The chairman of the Committee on Public Relations is ex officio a member of the Council.

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Communications for the Public Relations Department should be addressed to the Director, George H. Kress, M. D., Room 2004, 450 Sutter Street, San Francisco.

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Orville Meland (Sec'y for Southern Section)	Los Angeles	1941
A. Herman Zeiler	Los Angeles	1941
Gertrude Moore	Oakland	1941

Communications for the Cancer Commission should be addressed to the Secretary, Otto H. Pflueger, M. D., Room 2004, 450 Sutter Street, San Francisco.

(Roster lists of officers of scientific section, component county societies, Woman's Auxiliary, A. M. A. delegates, special committees, etc., are continued on advertising pages 4 and 6.)

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Trichinosis.—The preparation of a new and improved antigen for the diagnosis of trichinosis was recently described by Associate Zoölogist John Bozicevich of the National Institute of Health in the twelfth of a series of studies on this disease (*Public Health Reports,* December 2, 1938).

The new type of antigen may be used in connection with two previously devised diagnostic tests and evidence indicates that better results are obtained with the new antigen than with types of antigen employed previously. One method, similar in technique to Schick test for diphtheria, consists of injecting a small amount of trichina antigen into the skin, and later examining the site of injection to determine whether any reaction has taken place. The other method, the so-called precipitin test, is carried out in a test tube by overlaying a small amount of the patient's blood serum with an equal amount of various dilutions of the antigen. The study in question was undertaken with a view of improving the trichina antigen in order that more reliable results might be obtained in the diagnosis of the disease by these two methods.

Antigen prepared by this new method—involving isolation of trichina larvae, drying, and extraction with a neutral salt solution without the use of chemical preservatives or added extra salts—exhibits a marked specificity and excellent keeping qualities. Samples exposed to sunlight and room temperatures for periods as long as six months have shown no loss of potency when tested by the precipitin method. The material may also be put up in hermetically sealed vials and stored until needed.

Trichina antigen prepared in the new manner and used for precipitin and intradermal tests in an outbreak of trichinosis in Vermont, proved very effective for diagnosing cases of the disease. Forty-four hospitalized patients eventually reacted to both tests. However, two much reliance should not be placed on a single intradermal or precipitin test in diagnosing suspected cases of the disease. Since all persons suffering from trichinosis do not react in the same manner or at the same period of time following infection, evidence indicates that clinical symptoms, the differential blood picture, and other factors should be taken into consideration in establishing a diagnosis.

While a total of only 5,000 to 6,000 cases of trichinosis have been recorded in the United States since the disease was first recognized as a clinical entity, the results of more than 3,000 examinations conducted in the National Institute of Health indicate that approximately one of every six persons represented in the survey was infested with the trichina parasite. Heavy infestations, capable of producing clinical symptoms of trichinosis, were sufficiently numerous to warrant the belief that the disease occurs far more frequently than health reports indicate. Now that supplies of the improved antigen are available for use by physicians, it seems probable that more cases of trichinosis will be recognized.

Authorities point out that the geographic distribution of reported cases of trichinosis in the United States is correlated rather closely with the practice of feeding uncooked garbage to hogs. Hogs maintained on uncooked garbage have shown an incidence of trichinae of approximately 5 per cent and at the present time pork from such swine appears to be the chief source of trichinosis in man. The states of New York, California, Massachusetts, and Pennsylvania in the order named lead all others in the number of reported cases of the disease. In these states the feeding of uncooked garbage to swine is extensively carried on.

Evidence indicates also that many municipalities are contributing directly to the spread of trichinosis through sanction of the practice of feeding uncooked garbage to swine, maintained either on farms operated by the municipality or on farms operated by private contractors. Such hogs are usually slaughtered locally thus exposing inhabitants of the same city to the dangers of trichinosis.

Public health workers point out that it is a simple matter for the individual to guard against the contraction of the disease—the mere matter of cooking pork until it is thoroughly done is a sufficient measure of protection. The occurrence of the disease, therefore, is not a reason for restricting the consumption of pork but rather a reason for cooking pork well prior to its use.

ROSTER OF COUNTY MEDICAL SOCIETIES, CALIFORNIA MEDICAL ASSOCIATION

(County society secretaries are requested to promptly notify "California and Western Medicine" when changes are indicated in their roster information.)

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2404 Broadway, Oakland

President, Frank H. Bowles, 1624 Franklin Street, Oakland.

Secretary, Gertrude Moore, 2404 Broadway, Oakland.

Meeting, *Third Monday, 8:15 p. m., Hunter Hall, Oakland.*

Butte County Medical Society

President, E. L. Meyers, Fourth Street and Broadway, Chico.

Secretary, J. O. Chiapella, 131 Broadway, Chico.

Meeting, *Second Thursday.*

Contra Costa County Medical Society

President, Kaho Daily, 314 Tenth Street, Richmond.

Secretary, Clifford E. Dieterich, 1306 Pomona Avenue, Crockett.

Meeting, *Second Tuesday, 8 p. m.*

Fresno County Medical Society

President, Roland W. Dahlgren, 1006 Mattei Building, Fresno.

Secretary, Lester R. Nielson, 1006 Mattei Bldg., Fresno.

Meeting, *First Tuesday, University-Sequoia Club, Fresno.*

Humboldt County Medical Society

President, Samuel P. Burre, 507 F Street, Eureka.

Secretary, Joseph S. Woolford, 350 E Street, Eureka.

Meeting, *First Thursday.*

Imperial County Medical Society

President, Henry B. Graeser, 115 E. Fifth Street, Holtville.

Secretary, William A. Clarke, Holtville.

Meeting, *Third Tuesday, 7 p. m., Barbara Worth Hotel, El Centro.*

Kern County Medical Society

President, C. I. Mead, Haberfelde Building, Bakersfield.

Secretary, C. S. Compton, 428 C Street, Bakersfield.

Meeting, *Third Thursday, 8:00 p. m.*

Kings County Medical Society

President, P. K. Edmunds, Corcoran.

Secretary, William A. Johnstone, Hanford.

Meeting, *Second Monday, 8 p. m., Legion Hall, Hanford.*

Lassen-Plumas-Modoc County Medical Society

President, C. I. Burnett, Susanville.

Secretary, Fred J. Davis, Jr., Westwood.

Meeting, *On Call.*

Los Angeles County Medical Association

1925 Wilshire Boulevard, Los Angeles

President, William H. Daniel, 1930 Wilsbire Boulevard, Los Angeles.

Secretary, George D. Maner, 1925 Wilshire Boulevard, Los Angeles.

Meetings, *First and Third Thursdays, 1925 Wilshire Boulevard, Los Angeles.*

Marin County Medical Society

President, Harry N. Hensler, Home Market Building, San Anselmo.

Secretary, Carl W. Clark, 510 B Street, San Rafael.

Meeting, *Fourth Thursday, 7:00 p. m., Marin Golf and Country Club.*

Mendocino-Lake County Medical Society

President, Robert B. Smalley, Willits.

Secretary, Dallas Wagner, Fort Bragg.

Meeting, *On Call.*

Merced County Medical Society

President, E. M. Soderstrom, Merced.

Secretary, Fred O. Lien, Shaffer Building, Merced.

Meeting, *Third Thursday, Hotel Tioga, Merced.*

Monterey County Medical Society

President, Walter P. Farr, 308 Main Street, Salinas.

Secretary, Herbert Archibald, Salinas National Bank Building, Salinas.

Meeting, *First Thursday.*

Napa County Medical Society

President, Walter Rapaport, Imola.

Secretary, M. M. Booth, Bruck Building, St. Helena.

Meeting, *First Wednesday.*

Orange County Medical Society

President, G. Wendell Olson, 211 No. Pomona St., Fullerton.

Secretary, Glenn Curtis, 323 So. Pomona Street, Brea.

Meeting, *First Tuesday, 8 p. m., Chapel of the Orange County Hospital, Orange.*

Placer County Medical Society

President, William M. Miller, Auburn.

Secretary, Robert A. Peers, Colfax.

Meeting, *At Call of President.*

Riverside County Medical Society

President, N. K. Bear, 3655 Fourteenth Street, Riverside.

Secretary, Thomas A. Card, 3616 Main Street, Riverside.

Meeting, *Second Monday, 8 p. m., Library, Riverside Community Hospital.*

Sacramento Society for Medical Improvement

President, Dave Dozier, California State Life Building, Sacramento.

Secretary, Glenn E. Millar, 321 Physicians Building, Sacramento.

Meeting, *Third Tuesday, 8:30 p. m., Auditorium, Sacramento.*

San Benito County Medical Society

President, J. M. O'Donnell, Hollister.

Secretary, L. E. Smith, Hollister.

Meeting, *At Call of President.*

San Bernardino County Medical Society

President, Delbert B. Williams, 1151 D Street, San Bernardino.

Secretary, A. E. Varden, Medico-Dental Building, San Bernardino.

Meeting, *First Tuesday, 8 p. m., San Bernardino County Charity Hospital.*

San Diego County Medical Society

Fourteenth Floor, Medico-Dental Building, 233 A Street, San Diego

President, Bryant R. Simpson, 1205 Medico-Dental Building, San Diego.

Secretary, W. H. Newman, Medico-Dental Building, San Diego.

Meeting, *Second Tuesday, El Cortez Hotel.*

San Francisco County Medical Society

2180 Washington Street, San Francisco

President, Edwin L. Bruck, 384 Post Street, San Francisco.

Secretary, Stanley H. Mentzer, 2180 Washington Street, San Francisco.

Meetings, *Every Tuesday, 8:15 p. m., 2180 Washington Street, San Francisco.*

San Joaquin County Medical Society

President, N. P. Jobnson, Medico-Dental Building, Stockton.

Secretary, George H. Rohrbacher, Medico-Dental Building, Stockton.

Meeting, *First Thursday, 8:15 p. m., Medico-Dental Club Rooms, Stockton.*

San Luis Obispo County Medical Society

President, J. B. V. Butler, 722 Marsh Street, San Luis Obispo.

Secretary, E. M. Bingham, County Health Department, San Luis Obispo.

Meeting, *Third Saturday, 6:30 p. m., Gold Dragon Cafe, San Luis Obispo.*

San Mateo County Medical Society

President, N. D. Morrison, 205 Third Avenue, San Mateo.

Secretary, J. Garwood Bridgman, 205 Third Avenue, San Mateo.

Meeting, *Fourth Wednesday, Benjamin Franklin Hotel, San Mateo.*

Santa Barbara County Medical Society

President, W. H. Johnston, 1515 State Street, Santa Barbara.

Secretary, D. H. McNamara, 317 W. Pueblo Street, Santa Barbara.

Meeting, *Second Monday, Cottage Hospital.*

Santa Clara County Medical Society

President, Cletus S. Sullivan, Bank of America Building, San Jose.

Secretary, Leslie B. Magoon, 652 East Santa Clara Street, San Jose.

Meeting, *Third Wednesday, 8 p. m., Medico-Dental Building, San Jose.*

Santa Cruz County Medical Society

President, John T. Harrington, 10 Cooper Street, Santa Cruz.

Secretary, Samuel B. Randall, 84 Walnut Avenue, Santa Cruz.

Meeting, *First Monday, 7:30 p. m., Club Rio del Mar, Aptos.*

Shasta County Medical Society

President, B. F. Saylor, Redding.

Secretary, Morton J. Murphy, 1542 Market Street, Redding.

Meeting, *Second Monday.*

Siskiyou County Medical Society

President, J. B. McGuire, Mt. Sbasta.

Secretary, Victor W. Hart, 113 No. Oregon Street, Yreka.

Meeting, *Sunday on call.*

Solano County Medical Society

President, Ream S. Leachman, 727 Sonoma Street, Vallejo.

Secretary, Jobn W. Green, Box 539, Vallejo.

Meeting, *Second Tuesday, 8 p. m., Casa de Vallejo Hotel, Vallejo.*

Sonoma County Medical Society

President, D. C. Oakleaf, 301A West Street, Healdsburg.

Secretary, T. E. Albers, 600 B Street, Santa Rosa.

Meeting, *Second Thursday.*

Stanislaus County Medical Society

President, John A. Cooper, 1024 J Street, Modesto.

Secretary, Hoyt R. Gant, 403 Beaty Building, Modesto.

Meeting, *Second Tuesday.*

Tehama County Medical Society

President, Donald E. Thompson, Red Bluff.

Secretary, F. J. Bailey, Red Bluff.

Meeting, *At Call of President.*

Tulare County Medical Society

President, E. R. Zumwalt, Tulare.

Secretary, Karl F. Weiss, Security First National Bank Building, Visalia.

Meeting, *Sunday Evening once a month.*

Ventura County Medical Society

President, Grundy C. Coffey, Bank of America Building, Ventura.

Secretary, A. A. Morrison, 625 Main Street, Santa Paula.

Meeting, *Second Tuesday, Ventura County Country Club.*

Yolo-Colusa-Glenn County Medical Society

President, H. G. Potter, Winters.

Secretary, W. J. Blevins, Jr., Woodland.

Meeting, *First Tuesday.*

Yuba-Sutter County Medical Society

President, P. E. Thunen, I. O. O. F. Building, Marysville.

Secretary, Leon M. Swift, I. O. O. F. Building, Marysville.

Meeting, *First Tuesday.*

(Roster lists continued on advertising page 6)

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One-eyed Drivers.—One to two per cent of drivers are completely blind in one eye, but a more serious problem is presented by the fact that between 20 and 40 per cent of all motorists have a deficient eye which handicaps them. No state prohibits either group from driving. This is brought out in a report on "One-eyed Drivers" in the current issue of *The Sight-Saving Review*, quarterly journal of the National Society for the Prevention of Blindness. The authors of the report—H. R. DeSilva, W. H. Frisbee, Jr., and P. Robinson—are research associates in the Institute of Human Relations at Yale University.

"Only about twenty states make any check on vision for the driver's license," the report says. "There is, however, no agreement regarding visual standards. A reason for the absence of uniformity lies in the lack of attested facts on the part played by vision in driving. The standards suggested by different individuals or agencies do not conform with one another. The fact that they vary among themselves and are based upon insufficient research shows the need for further investigation."

The authors reached the conclusion that "most one-eyed and deficient-eyed drivers are oblivious to the defects which predispose them to accidents. The greatest human hazard arises not from the defects but from ignorance of the dangers from such defects. For most of these drivers the solution lies in personal reëducation adapted to their individual needs. For others, and especially those who have shown themselves incapable of profiting from reëducation, the solution lies in revocation of their licenses."

The one-eyed person is particularly handicapped in night driving, the report points out, adding: "Not only is a one-eyed person more sensitive to glaring lights, but it takes him much longer to recover from the glare and to see the road clearly again. The one-eyed motorist should drive as little as possible at night.

"The field of vision for a one-eyed individual depends partly upon the protrusion of his good eye and the bridge of his nose. The person with pop-eyes and a small nose will naturally see farther around his nose than a person with deep-set eyes.

"The most obvious compensation for the handicap of having one eye is for the driver to keep his head turned at an angle so as to spread his visual field evenly on both sides. Many one-eyed persons do not compensate nearly enough, since turning the head attracts attention and they are anxious to conceal their defect.

"Another form of correction possible is to keep the head and the eyes roving continually from right to left while driving in order to bring possible dangers from the side into the field of clear vision of the good eye. This habit is unfortunately not common enough among one-eyed persons.

"The hazards of driving are not the same for the right-eyed and the left-eyed driver, since we steer our cars from the left-hand side and drive on the right side of the road.

"Left-eyed persons with deficient or blind right eye have difficulty: (1) In perceiving pedestrians stepping off sidewalk, or walking along the roadway either by day or night; (2) in viewing road when making a right turn; (3) in perceiving cars approaching from the right of intersections; (4) in passing other cars (apt to cut in too soon or clip rear bumper in cutting out); (5) in perceiving road signs and traffic lights; (6) in backing out from angle parking; (7) in perceiving cars parked at an angle backing out; and (8) in keeping on right side of road (on account of inability to see edge of road easily).

"Right-eyed persons with deficient or blind left eye have difficulty: (1) In perceiving pedestrians on account of losing them in blind spot; (2) in viewing road when making a left turn; (3) in perceiving cars approaching from the left at intersections; (4) in avoiding oncoming cars (since they guide by right edge of road); (5) in perceiving road signs, on account of losing them in blind spot; (6) in backing out from parallel parking; (7) in perceiving jay walkers in middle of road; and (8) in watching traffic in rear mirror when located on side, as in a truck."

In 1937, 1,803 suicides were registered in California as compared with 1,602 suicides recorded in 1936. During recent years, presumably because of the economic depression, the suicide rates have been unusually high.

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Sacramento—State Office Building, Tenth and L streets. CApital 2800.
Los Angeles—State Office Building, 217 West First Street. MAdison 1281.
President, Howard Morrow, San Francisco.
Director, Walter M. Dickie, State Building, San Francisco.

California Northern District Medical Society

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Board of Medical Examiners of the State of California

San Francisco, Room 214, 515 Van Ness Avenue.
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President, William H. Barrow, 1400 Medico-Dental Building, San Diego.
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The Public Health League of California

Executive Secretary, Ben H. Read. San Francisco office, 244 Kearny Street, Phone SUtter 8470, Los Angeles office, Room 563, 1151 South Broadway, Phone PRospect 5711.

Better Health Foundation

President, Reginald Knight Smith,* 490 Post Street, San Francisco.
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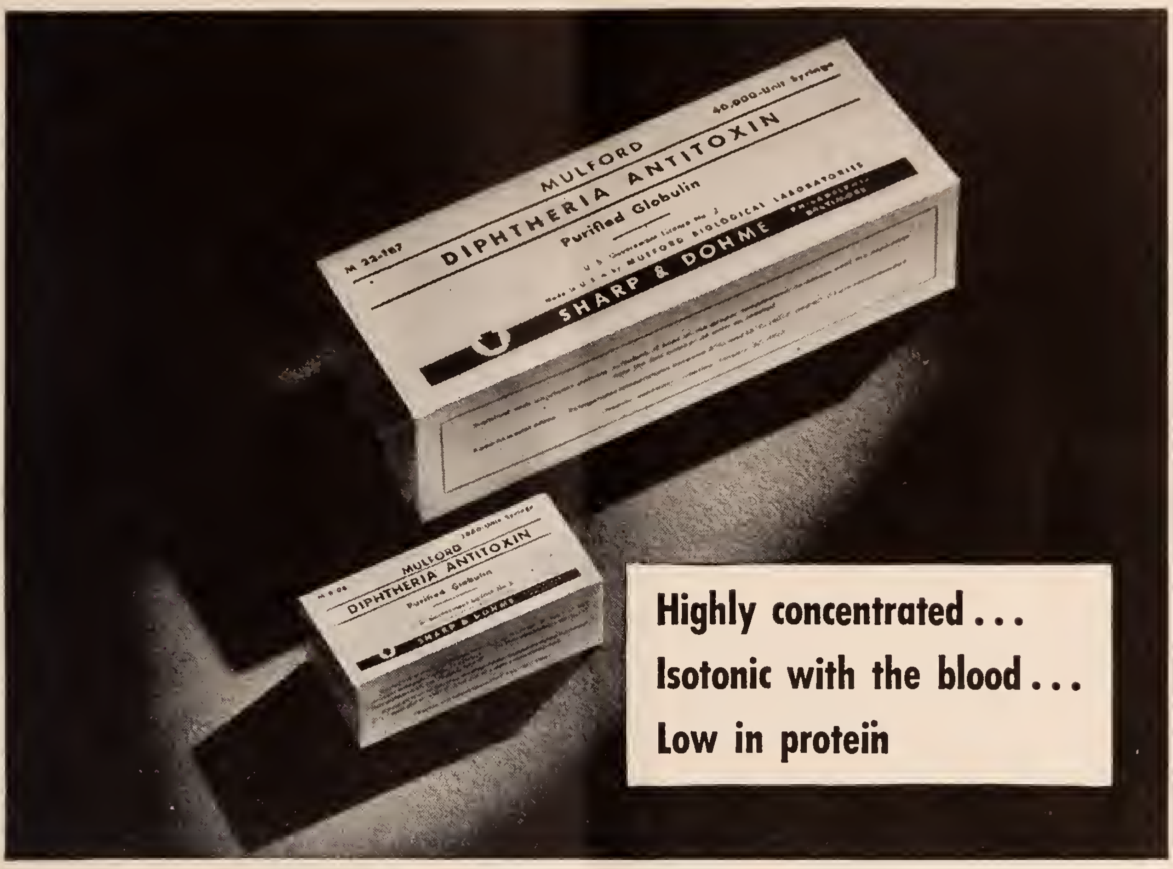
* Deceased.



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We invite and urge you to use this Service. It is absolutely *free* to every member of the California Medical Association. The Coöperative Bureau is equipped with catalogues and price lists of manufacturers, and can supply you information by return mail.

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(The Pioneer Post-Graduate Medical Institution in America)

Eye, Ear, Nose and Throat

Proctology, Gastro-Enterology
and ALLIED SUBJECTS

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NASAL SYPHON
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SPECIAL OFFER!
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NICHOLS
NASAL SYPHON, Inc.
Dept. CC, 144 E. 34th St., N. Y. C.

New York Polyclinic Medical School and Hospital.—"The Clinical Society of the New York Polyclinic Medical School and Hospital held its monthly meeting on Monday evening, January 8, 1939, at which time the following program was presented:

1. "The Prostate and the Practitioner" by Joseph F. McCarthy, M.D., Professor of Urology, New York Polyclinic Hospital. Discussion to be opened by J. Sydney Ritter, M.D., and Samuel E. Kramer, M.D.

2. "Recent Advances in the Treatment of Internal Diseases" by Llewellys F. Barker, M.D., Baltimore, Maryland. Discussion to be opened by Orrin S. Wightman, M.D., Bernard Sachs, M.D. and James P. Croce, M.D.

3. "Clinical Diagnosis of Peripheral Vascular Diseases—Motion Pictures" by Benjamin Jablons, M.D., New York Polyclinic Hospital.

Dr. H. M. Eberhard, Professor of Gastro-enterology at Hahnemann Medical School, Philadelphia, Pennsylvania, read a paper on "The Effect of Hot and Cold on the Gastro-Inestinal Tract" on Thursday, December 15 at 3:30 p. m.

Dr. Rudolf Schindler, Chicago, Illinois, read a paper on "The Clinical Value of Gastroscopy" on Wednesday, November 30, at 2:30 p. m.

Death from Natural Causes Is Rare.—Death from natural causes is one of the rarest occurrences among the human race, says William R. P. Emerson, M.D., in an article "Extending Our Years," in the December issue of *Hygeia.* The death rate from heart disease, cancer, apoplexy, pneumonia, accidents, nephritis (kidney trouble), tuberculosis, diabetes and appendicitis is completely out of proportion to the low mortality rate possible if the available knowledge of preventive medicine were applied to the fullest extent.

The first positive step in circumventing death is a thorough physical examination. Many ailments—diabetes and kidney trouble, for instance—can exist for years without obvious symptoms.

Even valvular heart trouble can be present throughout life without a patient being conscious of it until the fatal attack occurs. By detecting the first signs of deterioration in our organs these periodic examinations can forestall death.

The fact that human life, on the average, has been prolonged twenty years during the past century is due almost entirely to the reduction of infant and child mortality. After thirty-five, life has not been extended a single year in the last two generations. Between fifty and seventy, life expectancy is not so great as it was a century ago, despite the brilliant achievements of medicine and surgery.

To compensate for this, then, the periodic health examination is necessary. If one is overweight, he should let the doctor prescribe a reducing diet that will take off not more than one pound a week. Sensible reducing is the best possible life assurance, for after thirty-five, mortality increases 1 per cent for every pound of overweight.

Noisy work performed in a confined space is more harmful to the ears than if done in the open air.

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Incorporated not for profit
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MEDICINE—Personal Courses and Informal Course starting every week. Two Weeks Course in Internal Medicine, starting June 5, 1939.
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GYNECOLOGY—Two Weeks Course starting February 27, 1939. Clinical and Personal Courses starting every week.
OBSTETRICS—Two Weeks Intensive Course starting March 13, 1939. Informal Course starting every week.
FRACTURES AND TRAUMATIC SURGERY—Informal Course every week; Intensive Ten-Day Course starting February 13, 1939.
OTOLARYNGOLOGY—Two Weeks Intensive Course starting April 10, 1939. Informal Course starting every week.
OPHTHALMOLOGY—Two Weeks Intensive Course starting April 24, 1939. Informal Course starting every week.
CYSTOSCOPY—Ten Day Practical Course rotary every two weeks.
General, Intensive and Special Courses in all branches of Medicine, Surgery and the specialties.
●
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Address: Registrar, 427 South Honore Street, Chicago, Ill.

HOSPITALS AND SANATORIUMS

The Institutions here listed have announcements in this issue of CALIFORNIA AND WESTERN MEDICINE. For Index, see advertising page 8.

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For Treatment of Tuberculosis
San Jose, California

CALIFORNIA SANITARIUM
For Treatment of Tuberculosis
Belmont, California

CANYON SANATORIUM
For Treatment of Tuberculosis
Redwood City, California

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For Treatment of Alcoholic and Narcotic Addiction Diseases
2030 Griffith Park Boulevard, Los Angeles

COLFAX SCHOOL FOR THE TUBERCULOUS
For the Treatment of Tuberculosis
Colfax, California

COMPTON SANATORIUM AND LAS CAMPANAS HOSPITAL
Neuropsychiatric and General
Compton, California

FRANKLIN HOSPITAL
Limited General Hospital
Fourteenth and Noe Streets, San Francisco

FRENCH HOSPITAL
General Hospital
Geary at Fifth Avenue, San Francisco

GREENS' EYE HOSPITAL
Consultation, Diagnosis and Treatment of Diseases of the Eye
Bush and Octavia Streets, San Francisco

LAS ENCINAS SANITARIUM
Nervous and General Diseases
Las Encinas, Pasadena, California

LIVERMORE SANITARIUM
Nervous and General Diseases
Livermore, California

OAKS SANITARIUM
For Treatment of Tuberculosis
Los Gatos, California

POTTENGER SANATORIUM AND CLINIC
For the Treatment of Tuberculosis
Monrovia, California

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Mental and Nervous Alcoholic and Drug Addictions
1500 Page Street, San Francisco, California

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Limited General Hospital
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Limited General Hospital
27th and Valencia Streets, San Francisco

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Fatigue states, neuroses, and selected mental cases.
ALLEN WILLIAMS, M. D. *Internal Medicine*
Telephone BELMONT 111
WILL REBEC, M. D. *Psychiatry*

The American Social Hygiene Association.—A $15,000 gift to the National Anti-Syphilis Committee of the American Social Hygiene Association raises the total in its $500,000 appeal to $187,065 and will aid in promoting National Social Hygiene Day, February 1.

This was anounced by Dr. Ray Lyman Wilbur, president, following action of the Administrative Committee in naming the date for the annual nation-wide observance. The donor requested that the gift be anonymous.

Third Social Hygiene Day is expected to exceed in scope and effectiveness the observance of the last two years, according to Dr. Walter Clarke, executive director. He stated that evidences in the association's New York and San Francisco offices indicate that larger numbers of voluntary health and welfare agencies, civic groups, service clubs, women's organizations, churches, schools and other youth bodies were preparing for meetings and community-wide campaigns against syphilis on and near this date.

National slogan for the day, which will be marked by an estimated 5,000 town and city social hygiene programs, is "guard against syphilis." Objectives of the 1939 offensive against syphilis, toward attainment of which Social Hygiene Day was said to provide an avenue of approach, were stated in terms of the association's new "eight-point program on forty-eight state fronts."

These include plans to:

Organize more local and state committees to fight syphilis and gonorrhea.

Encourage passage of laws for prevention of syphilis in marriage and childhood.

Fight prostitution and medical quackery.

Aid employers and employees against the economic losses caused by these diseases.

Extend information on social hygiene to the youth of America.

Expand the personal advisory and consultation service.

Guide parents, teachers and pastors in sound principles of sex education of youth.

Continue observations and reports to citizens regarding official programs.

Marihuana. — Marihuana, as produced in the United States, presents a problem to chemists, agronomists and pharmacologists, as well as sociologists, it was reported today by United States Commissioner of Narcotics Harry J. Anslinger, following the first general conference on the problem, held in the Bureau of Internal Revenue Building.

While Federal and State agencies have discussed the marihuana problem, this was the first occasion on which chemists and educators met with Federal representatives.

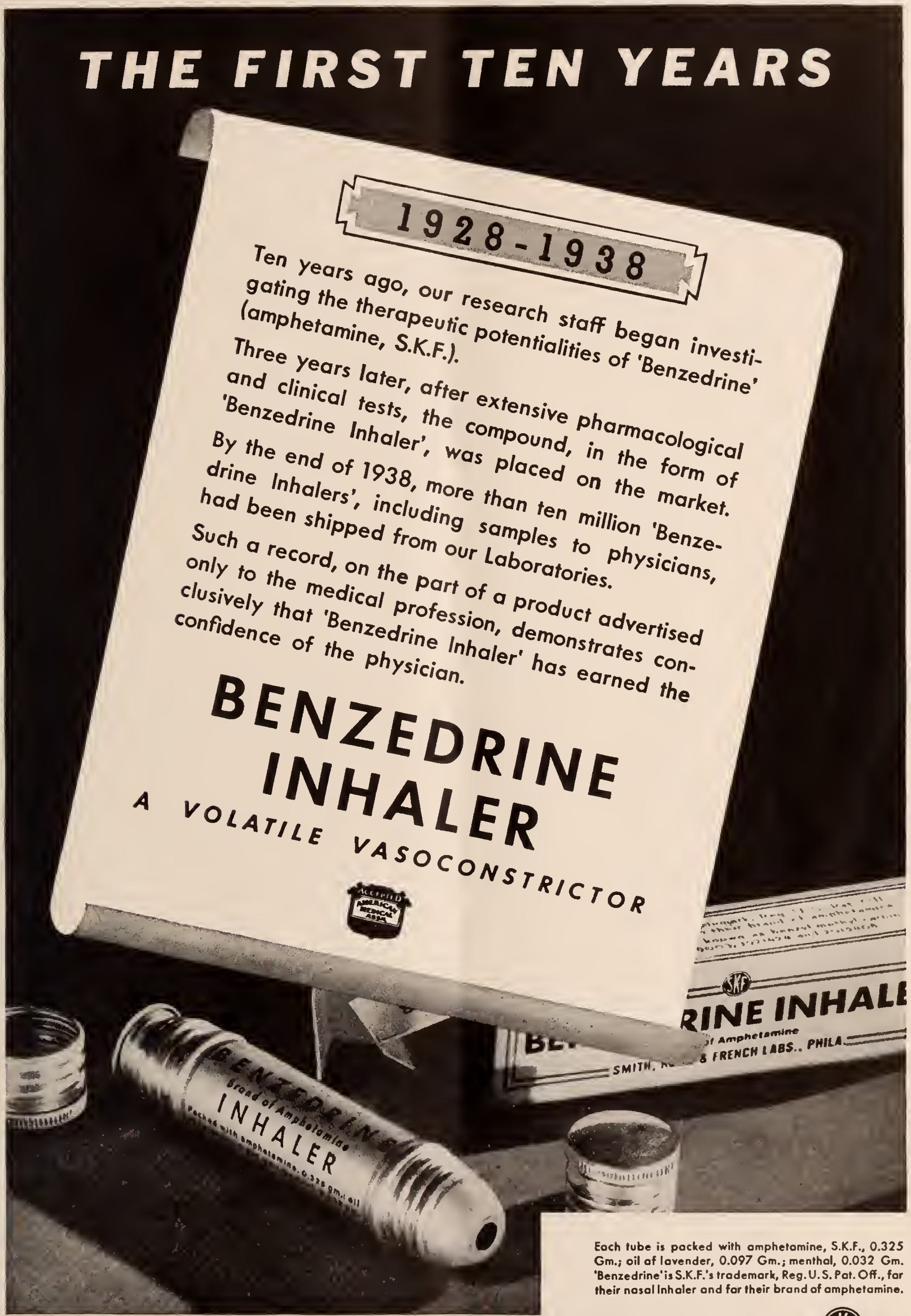
Two immediate problems in the study of the drug obtained from Indian hemp, Mr. Anslinger declared following the conference, are the necessity of determining the active constituents of the narcotic obtained from the hemp plant, and to perfect a hemp variety that will fill industrial requirements while producing a negative quantity of marihuana.

Chemists generally are agreed that cannabinol, the oily narcotic resin derived from hemp, contains more than one drug, although experiments so far have failed to isolate or identify them.

To facilitate this study, Herbert J. Wollner, consulting chemist of the Treasury Department, has perfected plans with other Federal educational and private research agencies.

Sandoz Chemical Works, Inc., West Coast Branch, Pharmaceutical Dept. — The Sandoz Chemical Works, Inc., has opened a West Coast branch, located at Room 312, 450 Sutter Street, San Francisco. This office is managed by Harry Althouse, and is staffed adequately to handle all inquiries pertaining to Sandoz products. Catalogs will be sent on request. Telephone YUkon 2454.

Regimen is better than physic. Every one should be his own physician. We ought to assist and not to force nature. Eat with moderation what agrees with your constitution. Nothing is good for the body but what we can digest. What medicine can procure digestion? Exercise. What will recruit strength? Sleep. What will alleviate incurable evils? Patience.—Voltaire.



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Three years later, after extensive pharmacological and clinical tests, the compound, in the form of 'Benzedrine Inhaler', was placed on the market.

By the end of 1938, more than ten million 'Benzedrine Inhalers', including samples to physicians, had been shipped from our Laboratories.

Such a record, on the part of a product advertised only to the medical profession, demonstrates conclusively that 'Benzedrine Inhaler' has earned the confidence of the physician.

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A VOLATILE VASOCONSTRICTOR

Each tube is packed with amphetamine, S.K.F., 0.325 Gm.; oil of lavender, 0.097 Gm.; menthol, 0.032 Gm. 'Benzedrine' is S.K.F.'s trademark, Reg. U.S. Pat. Off., for their nasal Inhaler and for their brand of amphetamine.

SMITH, KLINE & FRENCH LABORATORIES, PHILADELPHIA EST. 1841

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Rates for these insertions are $4 for fifty words or less; additional words 5 cents each.

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Aluminum Cooking Utensils Harmless.—At regular intervals, health departments are besieged with inquiries relative to the assumed hazards to health that may lie in the use of aluminum cooking utensils.

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Aluminum salts are found in most of the vegetables, the underground roots of which are used for human consumption. There is a possibility that such salts constitute an essential ingredient in the diet of mankind. Even though aluminum salts from cooking utensils might be absorbed into food products, there is no possibility that they might be injurious to the health of any human being.

Golden Gate International Exposition: Tuberculosis Exhibit.—Tuberculosis not only can be prevented, it can be cured!

This outstanding medical achievement will be demonstrated to millions of California World's Fair goers during 1939 by the California Tuberculosis Association.

The exhibit will show the strides of science, stress the need of public education and coöperation. Microbes which cause the disease will be exposed and the simple, quick and accurate methods of diagnosis will be shown. The x-ray, the skin and sputum tests will be demonstrated.

Part of the display will be devoted to exhibits on tuberculosis treatment by rest, sunshine and surgery. Complete rest, long known as one of the best methods of treatment, still ranks high, and surgery, only newly developed, will be shown as an additional method of affecting a complete cure. The exhibitors will show how a lung may be collapsed, bringing about complete rest to the infected section.

The chemistry of the microbes will be revealed in one part of the display. Pasteurization of milk as a health factor will be demonstrated and other methods of prevention will be shown. Ford Higby, Executive Secretary of the Association, said other exhibits will indicate the work of his society in eradicating bovine tuberculosis from California dairies.

Uses to which the Christmas Seal money has been applied will be shown, and the vast clinical program carried on in California will be recounted. More than 70,000 school children went through clinics last year, that less than 300 were shown to have the adult type tuberculosis and only 30 per cent of the children had been exposed. All positive reactors were x-rayed.

The educational and rehabilitation phases of the association program will be presented also.

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BOOKS RECEIVED

The March of Medicine. Selected Addresses and Articles on Medical Topics, 1913–1937. By Ray Lyman Wilbur, M. D., President of Stanford University. Cloth. Pp. 280. Price, $2.75. Stanford University: Stanford University Press, 1938.

The New International Clinics. Original Contributions: Clinics; and Evaluated Reviews of Current Advances in the Medical Arts. Edited by George Morris Piersol, M. D., Professor of Medicine, Graduate School of Medicine, University of Pennsylvania, Philadelphia, Pa. Volume IV. New Series One (old 48th). Cloth. Pp. 349, illustrated. Philadelphia: J. B. Lippincott Company, 1938.

Clinical Laboratory Methods and Diagnosis. A Textbook on Laboratory Procedures With Their Interpretation. By R. B. H. Gradwohl, M. D., Director of the Gradwohl Laboratories, and Gradwohl School of Laboratory Technique; Formerly Director of Laboratories, St. Louis County Hospital; Pathologist to Christian Hospital; Director, Research Laboratory, St. Louis Metropolitan Police Department, St. Louis, Mo.; Commander, Medical Corps, Fleet, United States Naval Reserve. Second edition. Cloth. Pp. 1,607, with 492 illustrations in the text and forty-four color plates. Price, $12.50. St. Louis: The C. V. Mosby Company, 1938.

Medicine in Modern Society. By David Riesman, M. D., Professor of the History of Medicine and Professor Emeritus of Clinical Medicine, University of Pennsylvania. Cloth. Pp. 226. Price, $2.50. Princeton: Princeton University Press, 1938.

You and Heredity. By Amram Scheinfeld, assisted in the genetic sections by Dr. Morton D. Schweitzer, Research Geneticist, Cornell University Medical College. Cloth. Pp. 434, with four color plates, seventy-one line illustrations, maps and diagrams by the author, and six halftone reproductions from photographs. Price, $3.75. New York: Frederick A. Stokes Company, 1939.

BOOK REVIEWS

Bibliography of Rural Medicine. By David Kydd, M. D., The Mary Imogene Bassett Hospital, Cooperstown, New York. Cloth. Pp. 38.

In this pamphlet, Doctor Kydd has compiled some three hundred seventy-five references to literature dealing with rural medicine. The bibliography is fairly comprehensive, including current periodicals, official publications and several books which have established themselves as authoritative source material. References to rural medicine and public health in foreign countries are also listed, including those of the smaller countries of central Europe, as well as China and India in the Orient. Those references with foreign titles are, for the most part, given in brief line in English to indicate their contents.

The bibliography deals with nearly every phase of rural medicine, including economics, costs of medical care, population studies, medical practice, etc. One-third of the material, however, is concerned with service, conditions, organization and administration of public health in rural areas. Attention has largely been given to the literature of the last eight or ten years, and represents the experience and trends of recent years. The contents have been classified by authors, and to quote Doctor Kydd, "Rather than to strive for completeness, an attempt has been made in this bibliography of rural medicine to gather together a few of the articles that characterize the thought that has been given to the subject." On the whole, the author has succeeded in his endeavor "to provide certain initial foci or points of departure for a comprehensive investigation of the subject of rural medicine."

K. F. Meyer, M. D.

There were but three deaths from smallpox registered in California last year, and none in 1936. This would indicate that the disease, through vaccination, is kept in check.

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Lanza: Silicosis and Asbestosis	4.25
Maxon: Spinal Anesthesia	6.50
Munro: Cranio-Cerebral Injuries	4.00
Walton: Marihuana	3.00

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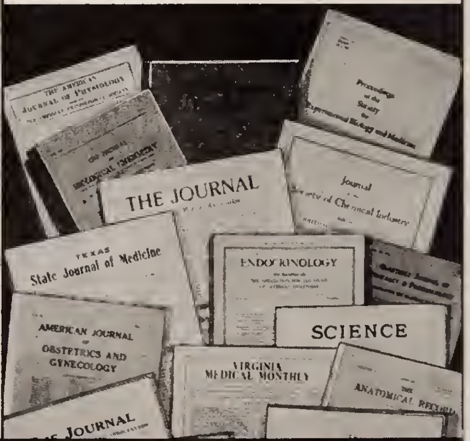
THE AMERICAN JOURNAL OF PHYSIOLOGY
Proceedings of the Society for Experimental Biology and Medicine
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Journal of the Society of Chemical Industry
TEXAS State Journal of Medicine
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TWENTY-FIVE YEARS AGO

(Continued from Text Page 80)

fully and well; we certainly are sorry to see him obliged, by such petty and mutton-headed interference, to sever his connection with the health work of the state.

* * *

School of Hygiene and Sanitation.—There exists at present no school of hygiene and sanitation on the Pacific Coast, a lack which we have every reason to believe will soon be supplied by the establishment of such a school in the University of California. The tardiness of the West in recognizing so important a field relating to the health of the public and in organizing an institution for the training of specialists in these lines, is more apparent than real, for the courses in public health given at the University are remarkably comprehensive. Indeed, these courses, which are described in a circular accessible to all who are interested, are so numerous and varied that the subjects making up a curriculum in public health are already quite completely covered. . . .

* * *

Very Important to You!—Two very important and far reaching economic conditions have their beginning this year of 1914. One is the new income tax law and the other is the state "Workmen's Compensation, Insurance and Safety Act," which goes into effect January 1. In regard to the income tax, every physician should carefully study his own income and more particularly his own expenses. Under the law, expenses necessary for the conduct of one's occupation may be deducted from the gross income; no small part of a physician's expenses are those required by the nature of his occupation and as such are not to be included in his taxable income. The *Journal of the American Medical Association,* in a recent issue, had an excellent editorial on this subject and particularly emphasized the fact that the law will have one good effect upon physicians, at least, for it will force them to be more accurate in the matter of their accounts. . . .

"Squeeze the Doctor" Again! . . . When commercialism comes into contact with professionalism, it almost invariably wins out. Heretofore we have had to fight commercialism in the shape of contract practice as organized by private enterprise and conducted more or less on the retail plan. With the coming of the "Workmen's Compensation, Insurance and Safety Act," however, we are confronted by commercialism on a wholesale scale and contract practice extended to the limit. The law is very complex and far reaching and it will take some time to find out exactly what it really means in many ways and just how it is going to work out. Some few essential points are pretty clear, however. All employees, except a few classes, must be cared for by the employer in the event of injury by accident and the salary must be paid during forced absence from work. . . .

Are we going to calmly accept what some one else is willing to offer or are we going to have a voice in fixing the amount of the fees that shall be paid to us for our services? That is the question, and the sooner we begin to discuss it seriously the better off we shall be in the long run. The actual fee schedule has not been finally determined by the insurance companies and it cannot be fixed for some few months, for it is not known how the act will work out nor how little physicians can be paid; but rest assured of one thing—the physician will be paid the smallest fee that the insurance companies can get him to accept! If all the members of the various county units will stand together in this matter, it is certain that satisfactory fees will be paid and that the financial burden will be placed where it belongs—on the business man employer, and not where the attempt will certainly be made wrongfully to place it—on the physician.

From an Original Article on "Rabies in San Francisco With Notes on Some Recent Additions to Our Knowledge of the Disease" by R. G. Broderick, M.D., San Francisco.—Since the widespread prevalence of rabies has produced numerous articles on the subject, the usual generalities will

(Continued on Next Page)

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TWENTY-FIVE YEARS AGO

(Continued from Preceding Page)

be omitted and attention directed to a consideration of the subject as indicated by title.

It is now about four years since the beginning of the present epizoötic of rabies in California began in Los Angeles. Previous to that time a small outbreak occurred in Los Angeles in 1898, which was suppressed by a muzzling ordinance. A few cases also occurred in 1906 among the animals of the Soldiers' Home near Los Angeles.

Rabies first appeared in San Francisco in October, 1911, when one case was reported by a veterinary surgeon. No other cases were reported until February, 1912, since which time there has not been a month, hardly a week, in which one or more cases were not reported. From the middle of February, 1912, to August 31, 1913, the laboratory of the San Francisco Board of Health has made 546 examinations for rabies, of which 355 were positive. The number and kind of animals were as follows:

Human	8	Cows	1
Dogs	328	Horses	2
Cats	11	Calves	1
Goats	4		

From an Original Article on "Points Regarding Tuberculosis of Interest to Health Officers" by Robert A. Peers, M.D., Colfax.—When asked to present a paper before your body it seemed to me that it might be of some value to you if I should speak upon the subject as shown on the programs, namely: Points Regarding Tuberculosis of Interest to Health Officers. Theoretically, that presented a subject very appropriate for the occasion. Practically, when I came to prepare my paper I asked myself, "What is there about tuberculosis of interest to the health officer that is not of interest to the public individually and collectively?" And indeed, anything intimately concerned with the control of the morbidity and mortality of the people, in order that we may attain the highest efficiency and achieve the most far-reaching results in matters pertaining to public health, must be made subject to very careful study by the layman as well as by the officially designated health officer. When that millennium arrives we may hope to conquer and wipe out all infectious diseases. In practice, however, the health officer, as the representative of the people, the one upon whose individual shoulders is thrust the collective burden of the community, is the one who does the work. . . .

From an Original Article on "The Relation of the Sanitarium to Vocational Guidance" by William Simpson, M.D., San Jose.—Every sanitarian, and particularly every health officer, must be an instructor and, as such, interested either for or against every educational movement. He must be for such movements as favor the physical development of the race which is the health officials' especial care. He must be against those which take from the boy or girl the full measure of growth to which each is entitled.

Thus far the boy has never been sized up by anybody but himself. No university graduates the girl in the knowledge of the duties and pleasures of motherhood, the one employment man can never take from her, and which she is taught to fear rather than welcome. Can we help these boys and girls to know their abilities and opportunities, or must they still blunder along and take their chances? Vocational guidance attempts to show the boy and girl how to grasp the opportunity and how to escape the blunders. . . .

From an Original Article on "Modifications in Administrative Measures Necessitated by the Carrier Problem" by F. W. Browning, M.D., Hayward.—The "carrier" problem confronts us very seriously in California for the reason that as yet the State Board of Health has not promulgated any regulations for the guidance of the health officer. Criticism, however, is not called for because no practical solution of the problem has been found. It is brought before this body of health officers at this time in the hope that practical

(Continued on Page 18)

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* *Excerpt from the lecture delivered during demonstrations of the Camp Transparent Woman exhibit to the laity.*

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TWENTY-FIVE YEARS AGO

(Continued from Page 16)

recommendations, even though of a temporary nature, may be offered for the consideration of the State Board of Health.

Rosenau makes the trite remark that "the relief of bacillus carriers is one of the rewardful problems in preventive medicine," whilst Albert of Iowa City, after reading a very excellent paper on the problem of the diphtheria "carrier" at the last meeting of the American Medical Association last June, which was freely discussed by eminent men, closes the discussion thus: "The number of methods that have been discussed emphasizes one of the conclusions that we made, viz., that no one method has as yet proved satisfactory for the proper treatment of the carrier condition."

Let us briefly consider the situation in California at this time in so far as it concerns diphtheria. . . .

From an Original Article on "Recent Legislation on Communicable Diseases in the United States" by John N. Force, M.D., Berkeley. — It is proposed in this paper to consider some recently published regulations and recommendations in the control of a group of communicable diseases which, for purposes of administration, have been designated as "Class A." These diseases are smallpox, scarlet fever, diphtheria and typhoid fever. In this connection a study has been made of all legislative acts and State Board of Health regulations, bearing on communicable disease control, which have been issued since June 30, 1911. . . .

The California Sanitary Code. The State Board of Health is engaged in the preparation of a sanitary code for California. The first portion of this code to be issued will deal with the control of communicable diseases. It will be supplied to health officers in the form of circulars, which will eventually be assembled in book form with a suitable index. . . .

From an Original Article on "Administrative Measures for the Control of Scarlet Fever" by J. J. Benton, M.D., Berkeley.—The conservation of the health of the community as a whole and the prevention of the spread of disease to the general public constitute the principal functions of the health officer. In dealing with the latter problem his administrative methods for control thereof will, of necessity, vary according as the specific disease falls within one or the other of the two great divisions of infectious or contagious diseases, viz., those the etiology and mode of transmission of which have been scientifically proven, and secondly, those whose causation and propagation have not been conclusively demonstrated. In the first category fall such diseases as diphtheria, plague, tuberculosis, typhoid fever, tetanus, yellow fever, malaria, rabies, etc.; while in the second are to be placed scarlet fever, measles, German Measles, whooping cough, mumps, etc. . . .

On the other hand, in dealing with the second class of infectious diseases—those in which the etiology and mode of transmission have not been scientifically proven—we should be very conservative in our methods and be sure of our ground before accepting new policies. . . .

From an Original Article on "Rating the Efficiency of Hospitals and Institutions for the Tuberculous" by Burt F. Howard, M.D., Sacramento.—One of the provisions of the new law creating a Department of Tuberculosis is that it

(Continued on Page 20)

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1. Holmes and Deuel: Am. Jrl. Physiol., Vol. 54, P. 479. (Confirmed in experiments with New Nucoa by university workers.)

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2. Munsell, Jrl. A. M. A., Vol. 111, P. 250, 1938.

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TWENTY-FIVE YEARS AGO

(Continued from Page 18)

shall be the duty of the director to inspect and investigate all institutions, both public and private, where tuberculous patients are treated. Also he shall prepare annually for each institution a report of its rating on sanitary construction, enforcement of sanitary measures, adequate provision for proper food, etc.

There are certain advantages of such a classification which suggest themselves. First, it is a sort of "taking of stock," as it will give the department more accurate knowledge than is now available as to one essential portion of its equipment for tuberculosis control, viz., the location, capacity and efficiency of hospitals and sanatoria treating tuberculosis.

By the word efficiency we need not understand merely technical success, but also a certain fitness for the desired end. Assuming that we have in every part of the state hospitals and sanatoria which are hygienic as to construction and management, give good food and all that can be desired in the way of nursing and medical attendance, there may yet be ways in which they are not efficient with regard to the problem of tuberculosis as a whole, for example: patients may not go to these institutions in such numbers as to essentially modify the total number uncared for, or they may remain in them too short a time to accomplish a cure or to obtain any adequate educational benefit. . . .

From an Original Article on "The Venereal Disease Problem" by Charles R. Blake, M.D., Richmond.—In a discussion of venereal diseases, I believe that a proper control of prostitution is the proper weapon. Prostitution is the burning question of the day. The interest in this question is nation wide and you can scarcely find any intelligent person who has not been thinking about it and who is not seeking information and advice. . . .

With the abolishment of the "redlight district" in San Francisco and eventually all over the state by law which will shortly be voted on by the people of this state, known as the "Abatement Law," and it will surely win, it will be absolutely up to the boards of health of all cities to formulate a plan, which should be the same all over the state, to exterminate, if possible, all venereal diseases. The police authorities are out of it, as they acknowledge by this law that they are not able to control prostitution or venereal diseases. I do not think there is any way of preventing private prostitution, but with the coöperation of all physicians and the expenditure of some money on the part of all the cities, venereal diseases would soon be under complete control. All cases, women and men, should be treated free of charge, if not able to pay, and should be kept under strict observation until a permanent cure is effected, and if necessary, hospitals should be provided or wards set aside especially for the treatment of all such diseases.

From an Original Article on "The Fifth Annual Conference of State, County, and Municipal Health Officials" by W. A. Sawyer, M.D., Berkeley.—The Fifth Annual Conference of State, County and Municipal Health Officials took place at Venice, California, from October 6 to 11, 1913. The conference was held in conjunction with the Sixteenth Annual Convention of the League of California Municipalities. The first day was devoted to registration, inspection of the manufacturers' and pure food exhibits, and attendance at the opening addresses before the general meeting. . . .

From an Original Article on "Pellagra" by R. W. Harbaugh, M.D., San Francisco.—Pellagra is a symptom complex rather than a disease, characterized by periodical manifestations of gastro-inestinal, skin, nervous and mental changes.

It was endemic in Spain in the year 1735. Cazal in 1762 described it as La Mal de la Rosa. Frapoli, in Italy, in 1771, called it "Pellagra" or "Dry-skin."

It next spread to France and Roumania, being reported in the latter part of the eighteenth century, and has only

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been recognized in the United States in the last fifty years.

At the present time there exist about 100,000 cases in Italy, 50,000 in Roumania, and fewer numbers in Spain, France, Portugal, and Egypt.

The first case in the United States was reported in South Carolina in 1908. Later cases were reported in Alabama. It has since been reported all over the United States, especially in the southeastern states. We have at present 50,000 to 60,000 cases in the south.

There were 368 deaths from the disease in the United States in 1910. . . .

From an Original Article on "Brief Notes on the Formation and Orthography and Pronunciation of Medical Terms" by Rev. W. H. Mills, Contab.—Some weeks ago Doctor Beason, in the course of an address given by him at one of these meetings, alluded to the fact that, in later life, we often forget, because we don't care to remember them, facts which as medical students we were required to assimilate; and therefore, when some occasion demands a knowledge of those facts, have to relearn them.

In a letter to the London *Spectator,* a few weeks ago, the writer, very properly objecting to such words as "pacificist" and "pacifist" as substitutes for "peacemaker," was unwise enough to suggest, as a better term, "paxamist"—a word which, though, to my amazement, it was commended by the Editor, is not merely a mongrel but also a monster. That letter, however, was not wasted. It called forth a protest from a philologist, who laid down three rudimentary rules for word-formation. "In coining new words," he said, "some regard should be paid to the following principles":

1. The idea, which the new word is intended to express, should be truly connoted in its constitution.

2. Languages, like liquors, should not be mixed.

3. The ordinary rules of grammar should be observed; and, if possible, the result should be euphonious.

These rules are at once very simple and very useful and they go a long way. But I may add one more.

4. In a compound word, made up of two nouns, the union of the nouns may not be interrupted by a preposition. Thus such a word as oothekektomy is wrongly formed:—Ovariotomy, by the way, violates rule 2; it is a mongrel, though some late Latin authors have coined a Latin tome from the Greek Touy. Now, when wrongly formed words have grown into inveterate use, it is very difficult, if not impossible, to alter them; the malformations have mostly to be endured. But, when the question is of recent words, or words as it were in the birth, it is surely most desirable that the rules of word-formation should be rigidly observed: that new words should be constructed on strict etymological lines; that recent malformations should be corrected; that wrongly formed words, claiming acceptance, should be rejected. . . .

From an Original Article on "Artificial Synostosis of the Tuberculous Spine" by James T. Watkins, M.D., San Francisco.—I ask you to ponder these four texts which I quote verbatim from the classics of orthopedic literature.

Bradford and Lovett's Text Book, 1911 edition, "On the Nature of Potts Disease": "It will always be regarded as one of the most formidable of diseases, its long course, the deformity entailed, the severity of the complications and the occasional termination in death give both to the surgeon and to the nonprofessional public a natural dread of the affection."

Henry Ling Taylor's Hand Book on "The Duration of the Disease": The disease is rarely cured in two years, and then only in the cervical spine. In other regions spinal support for four to five years, or more, is necessary. The course in untreated cases is very long—from five to twenty years.

Painter (Goldthwaite, Painter and Osgood): "Diseases of Bones and Joints" on the malignancy of Spinal tuberculosis.

It tends to recur after an apparent cure in a considerable proportion of cases—the average quiescence of cases being twelve and one-half years.

Wullstein, Joachimsthal's Handbuch: "Most authors agree that after the fortieth year of life a cure is no longer to be expected.". . .

(Continued on Next Page)

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TWENTY-FIVE YEARS AGO

(Continued from Preceding Page)

From an Original Article on "Recent Advances in the Treatment of Dacryostenosis" by Louis D. Green, M.D., San Francisco.—Operative procedures for the relief of dacryocystitis, by making an artificial communication between the tear duct and the nose, date back to the time of Galen and Celsus, but it is only in recent years that any real progress has been made in this direction.

Probing and slitting the duct and canaliculus, while curative in some cases, usually results in failure besides necessitating a painful and prolonged course of treatment. Extirpation of the sac, though more frequently successful, is also undesirable in that it interferes with or destroys the physiological function of the lacrimal apparatus, often failing to abolish the epiphora and therefore frequently demanding a partial or complete removal of the lacrimal gland, and finally is apt to leave a scar in a rather conspicuous place. . . .

From "The Twenty-ninth Annual Meeting of the Northern District Medical Society."—Was called to order by the President, D. H. Moulton, in the Hotel Sacramento, at 11 a. m., November 11, 1913.

The names of Drs. H. D. Bernard and E. H. Pitts were proposed for membership. Their names were referred to a board of two censors, Drs. J. H. Parkinson and R. A. Peers, appointed by the chair. An address of welcome was then delivered by Dr. S. E. Simmons. . . .

The Society then proceeded to the election of officers for the ensuing year. The following officers were unanimously chosen: President, J. W. James, Sacramento; first vice-president, R. N. Bramhall, Fair Oaks; second vice-president, T. H. Stice, San Jose; third vice-president, C. B. Jones, Sacramento; secretary, E. C. Turner, Sacramento. Censors—W. E. Briggs, A. M. Henderson, Sacramento; W. E. Bates, Davis; D. H. Moulton, Chico; W. S. Langdon, Stockton. . . .

From "Use of Heroin Spreading Rapidly Among Drug Fiends."—Washington, D. C.—According to information gathered by the United States Department of Agriculture, there has been a sudden and very significant increase in the use by persons with a drug habit of the little-known, but very dangerous drug called "heroin." The sales of this drug have recently increased greatly, particularly in those states which have rigid laws preventing the indiscriminate sale of morphin and cocain. Investigation of the subject establishes the fact that many drug victims who formerly used morphin and cocain, and who, under the new laws, find it difficult to obtain these substances, have begun using heroin, the sale of which is not as yet as carefully restricted under state laws. The drug is said to be fully as dangerous as morphin and by many is held to be much worse, for the reason that it occasionally kills the victim outright, and

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its habit is far harder to overcome than the use of the other drugs. The Department, pending further action, especially warns all people who are unfamiliar with the drug to avoid all preparations containing the substance and to take it only on the prescription of reputable physicians.

BOARD OF MEDICAL EXAMINERS

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of a little boy, scared and worn out by the ravages of the dreaded peritonitis, deprived of the company of his mother on his last ride, who turns his little prayers to his grandmother to please ride with him to the hospital.' Mrs. Volstad was convicted of manslaughter, which may result in a prison term of one to ten years, but her co-defendant, Rev. Wilbur W. Alvis, pastor of the Pentecostal Church of Highland Park, was acquitted. . . . In his ruling, Judge Schott upheld 'the efficacy of prayer' but castigated the two defendants for what he implied was gross negligence on their part for attempting to save the Volstad boy with prayer alone when physicians' diagnosis showed he needed immediate surgical attention. 'It is not the intention of this court to criticize any person who in good faith, regardless of his religious beliefs, attempts to pray and ask the good Lord to heal the sick and afflicted. But this court cannot countenance the tactics used by this defendant Alvis, a self-ordained minister who belongs to that group of religious racketeers of whom there are too many in this small world of ours. In the guise of minister of the Lord he serenaded this sick boy accompanied by a guitar player. Does he return again and pray for him? He does not. Does he inquire as to the boy's health? He does not.'. . . ." (Los Angeles *Daily News,* November 29, 1938.)

"Convicted of three counts of petty theft in connection with what police described as a 'phony healing racket,' Claude Benson, twenty-eight, Negro specialist in voodooism and mysticism, today will come up for sentence in Judge Clarence F. Terry's municipal court. Ralph Whitney, detective sergeant, said that Benson, using the name of Dr. C. B. Findley, went to the home of Mrs. Angie L. Cameron, 3206 Filbert Street, and said he would cure her illness for $15. After Mrs. Cameron paid half the fee, Benson prayed for her, using mysterious gestures, then left a bottle of medicine with her, Whitney said. 'After half an hour, throw this medicine over your left shoulder and you'll be cured,' Whitney quoted Benson as saying. The suspect assertedly warned Mrs. Cameron that 'if you don't send me the other $7.50 I'll put a curse on you and see that the illness returns.'. . ." (San Diego *Union,* December 1, 1938.)

"Denied a new trial, Mrs. Frances Zoffel, forty-five, nurse, convicted with Dr. Clayton E. May of conspiracy to commit an abortion, today faced an indeterminate sentence at Tehachapi Women's Prison. Superior Judge Alfred J. Fritz ordered the sentence to run concurrently with a five-year probationary sentence given her last year for a similar offense." (San Francisco *News,* November 4, 1938.) (Previous entries August and September, 1936.)

"To prevent possible loss by San Francisco doctors in a fake selling scheme, the Better Business Bureau asks that all doctors be on the lookout for 'Dr.' Andrew Dolte, discharged cyclopedia salesman for the F. A. Davis Company, Philadelphia, Pa. Dolte, who represented this company in California for six months, will soon be making local calls, it is believed. His plan is to call on doctors to whom he has made recent sales. 'A new edition is coming out in January,' he states, 'give me your old set and I'll put you down for a new one.' Dolte takes the old set, sells it for whatever he can get, and vanishes. If he comes your way, make an appointment for him to call back, then phone the Better Business Bureau." (*Bulletin, San Francisco County Medical Society,* December, 1938.)

"In the midst of his trial on a charge of practicing medicine without a license, William A. Van Buren changed his

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(Continued from Preceding Page)

plea from not guilty to guilty, was fined $200. Municipal Judge Twain Michelsen also sentenced Van Buren to six months in the county jail, then suspended sentence on probation, with the proviso he shall not even work in a physician's office during that time. On trial before a jury, Van Burean switched his plea on the second day of his trial at the conclusion of the testimony of the first witness, Mrs. Morris Pearson, an investigator for the State Board of Medical Examiners. Mrs. Pearson testified she went to Van Buren for treatment and that he prescribed for her after she had been examined by another man." (San Francisco *Call-Bulletin*, November 30, 1938.)

"'I paid him $50 and he promised to reduce me at least 25 pounds—but I gained seven pounds,' Miss Ethel Tucker, 1308 North Avenue 57, testified in small claims court this week. 'He said he would reduce me 20 pounds and I lost only three,' Miss Dorothy Sears of Long Beach testified. Miss Thacker said she weighed 160 pounds when Dr. Harry Soforenko accepted her $50 and gave her a receipt reading: 'Paid in full for reducing at least 25 pounds, September 3, 1937.' After taking exercises, shots in the arm and dieting for fourteen months, she said, she weighed 167 pounds. 'They cheated on their diet,' said Doctor Soforenko. On the theory that the receipts constituted guaranties, Judge Joseph Marchetti gave judgments for the plaintiffs." (Los Angeles *Highland Park News-Herald*, October 21, 1938.)

"Two cool bandits who answered phone calls in the office of their victim, held up and robbed Dr. William Edward Glaeser, beat and kicked him when he refused to write them a check for $500 and escaped, leaving the physician and his nurse tied and gagged. The two men, bandaged crudely about the face to hide their identity, entered the office at 196 Guerrero Street yesterday afternoon and asked for treatment of injuries received in an auto accident. When Doctor Glaeser questioned their bandages, one of them pulled a gun and demanded his money and watch, then asked for a check for $500. When the doctor refused they knocked him down and kicked him. Nurse Edith Macue, entering the room, was held at gun point while the robbers took $20 and a watch and then gagged and bound them both to chairs. While the robbery was in progress, the doctor's wife, who had been phoned by neighbors who heard the struggle, telephoned her husband. 'The doctor's out; I'll have him call you,' one of the men said to her. The bound pair were released by a visitor, Miss Ruth Jones, who heard the struggle from an adjoining room, but was afraid to try to reach a telephone." (San Francisco *Chronicle*, November 29, 1938.) Previous entries, May and July, 1932.)

"Charges by the State Board of Medical Examiners that a former undertaker has been treating alcoholics in San Francisco with a deadly South American arrow poison, brought indictments by the Grand Jury yesterday against four persons. Thomas F. Huston, proprietor of the Samaritan Treatment at 1153 Bush Street, and a former mortician, is charged with conspiracy to practice medicine without a license. Also accused are John A. Stevens, an assistant, Ruth Nielson and Juanita Butcher, nurses. The Grand Jury vote was taken following testimony of fourteen witnesses and a summation yesterday by Assistant District Attorney Harry J. Neubarth. The indictments were based mainly on information gathered by Joseph W. Williams and Thomas P. Hunter, special agents for the State Board. Dr. Charles B. Pinkham . . . said last night that investigators found more than 200 complaints had been made regarding the treatment, which consisted of administering nauseating drugs and curare, a poison used by South American Indians to tip their arrows. 'There was not sufficient medical advice,' said Doctor Pinkham. Denying that this is a test case to determine the strength of the Board, Doctor Pinkham said: 'It is no such thing. We are interested in

(Continued on Page 26)

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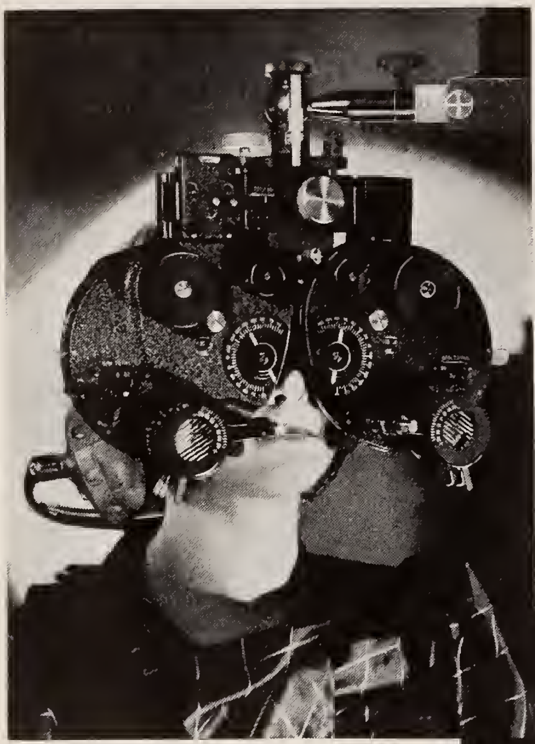

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BOARD OF MEDICAL EXAMINERS

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seeing that any institution for cures has sufficient medical advice and that the practice is not dangerous to the public.' The indictments will be returned Wednesday before Presiding Judge Ward." (San Francisco *Chronicle,* November 19, 1938.)

"Death yesterday threatened to forestall the trial of Dr. James E. Shafer, seventy-four, Berkeley physician, charged with performing an illegal operation. When the case came up for trial in the court of Police Judge Oliver Youngs, postponement was asked by Doctor Shafer's attorney on the plea that the physician was dangerously ill. Disturbed at the many delays, Judge Youngs ordered the trial transferred to Doctor Shafer's home at 2185 Woolsey Street. There the physician was found in a comatose condition, unable to answer questions of his counsel. The trial was postponed until March 2. Doctor Shafer is accused of performing an illegal operation on Mrs. Lee Etta Bruce, twenty, of 21681 Montgomery Avenue, Hayward. His nurse, Mrs. Erol Ward, forty-eight, also was named a defendant." (San Francisco *Chronicle,* December 2, 1938.)

"Dr. Francis D. Coltrin, a Fullerton physician, is now at home, having been granted a parole by the State Board of Prison Directors at their meeting on November 17, members of the family announced today in correction of a report that a sentence of ten years had been set in connection with an asserted illegal operation and the death of a sixteen-year-old Santa Ana high school girl more than two years ago." (Fullerton *News-Tribune,* November 25, 1938.)

"A little more than five years ago, Karl J. Weberg, Pasadena chiropractor, was acquitted on a murder charge which grew out of an illegal operation he was alleged to have performed. Yesterday in Justice Court, Weberg was arraigned on three counts of performing illegal operations. The chiropractor, who is reported to have a large practice in Pasadena, was arrested late Tuesday night by members of the police department vice squad following an extensive investigation. The formal complaint against Weberg alleged that he performed illegal surgery on a woman in June, 1938, and on another woman on two different occasions—in September, 1936, and in September, 1938. Both women are married. . . . Charges of murder and illegal surgery were filed against Weberg in January, 1933, following the painful death of a young, unmarried woman upon whom he was alleged to have performed an unlawful operation. The case was sensational and did not end until March 7, 1933, when a jury acquitted the chiropractor. . . ." (Pasadena *Independent,* November 4, 1938.) (Prior entries July, August, September, 1926; February, 1928; April, 1936.) The records of the Board of Medical Examiners indicate that Karl Weberg, asserted former member of the Pasadena Fire Department was, in 1922, one of the incorporators of the Pasadena College of Chiropractic, which he served as President, his name assertedly being listed in the faculty as in charge of the "Department of Philosophy."

"Milton T. Euler, sixty-seven, San Francisco, was found guilty Wednesday in Hayward justice court of giving medical treatment without a state physician's license. A jury deliberated an hour before bringing in the verdict. Mr. Euler faces a maximum sentence of six months in jail, $500 fine, or both, when he comes up before Judge Jacob Harder for sentence next Monday. Mr. Euler on the stand claimed his true name was Uhler, but admitted he has used both. . . . He explained the presence of "Dr." on his stationery and business cards by saying that as a boy he was christened Dr. Milton Taylor after a famous New York physician. Thomas P. Hunter, special agent for the State Board of Medical Examiners, worked up the case against Mr. Euler." (Hayward *Review,* December 1, 1938.)

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"A woman with an alleged penchant for signing names of physicians to checks for various amounts was named in a document issued by the district attorney, charging forgery. The complaint charged that a 'Mrs. J. W. Hynde' admitted to Sgt. Frank Beatty and Lt. O. C. Simmons, of police, that she had signed the name of Dr. E. H. Crabtree, November 23, to a check with which she purchased several articles of wearing apparel from a downtown store. Attached to the complaint, as additional evidence, were checks purportedly signed by Dr. A. L. Barr and Dr. W. O. Weiskotten, which the district attorney was informed were forgeries. Preliminary hearing of the case has been set for December 14 in municipal court. Writer of the checks was identified as an employee of a credit establishment, the district attorney commented." (San Diego *Tribune*, December 2, 1938.)

"Dr. George (Glenn) Granger White, Pacific Highway druggist, who was convicted by a jury on four counts of practicing medicine without a license, today was given a $1,000 suspended fine by Municipal Judge Eugene Daney, Jr., on condition he leave the state. White, it was brought out, formerly was a licensed physician, but had his permit revoked in 1937 by the State Board of Medical Examiners for malpractice. The jury found that recently White had been administering to several persons and had not had his license reinstated to him. Daney instructed the defendant to dispose of his San Diego property, including the drug store and Alpine land, and to leave the state as soon as possible. The ex-physician's plea to retain hypodermic needles for his own use was rejected by the court. Daney did, however, allow White to live with his son in Los Angeles for sixty days pending disposition of his San Diego holdings." (San Diego *Tribune*, December 2, 1938.) (Prior entries February, March and July, 1937.)

"Standing before the court with trembling hands, Dr. Clarence C. Chappelle, 66-year-old San Jose physician, yesterday pleaded guilty to a charge of performing an illegal operation upon an Oakland girl, October 7, and asked for probation. Superior Judge William James, before whom Doctor Chappelle appeared, continued the case until Friday in order to receive the report of Adult Probation Officer Max Watson. The elderly physician had practiced medicine for thirty years until his license was revoked recently by the State Medical Board on charges of performing an illegal operation on a San Francisco woman. At liberty under a $10,000 bond, Doctor Chappelle changed his plea to guilty yesterday after having pleaded not guilty after his arraignment. . . ." (San Jose *Mercury-Herald*, December 6, 1938.) (Prior entries December, 1938.)

"Paul DeGaston, one-time San Francisco art photographer, has fallen behind $2,040 in payments to his first wife for the support of their children—but he has found means to be married eight times since his first divorce. In a move to collect the $2,040 and also to modify the terms of their decree, Mrs. Leona DeGaston of Los Angeles, wife No. 1, made this allegation before Superior Judge C. J. Goodell here yesterday through Attorney Delbert W. Radke. At the time of the divorce, in 1923, Mrs. DeGaston was awarded custody of the children, Barbara and Gloria, and $60 monthly for their care as long as they remained in the Bay Area. In yesterday's petition, Radke pointed out that DeGaston has now moved to Los Angeles, and therefore, since he is in the same vicinity as the children, he should be ordered to pay the $60 monthly there. Judge Goodell issued an order for DeGaston to appear before Superior Judge I. L. Harris on December 16 and show cause why his wife's petition should not be granted, and why he should not be held in contempt of court for the alleged deficit of $2,040 in support money." (San Francisco *Examiner*, December 9, 1938.) (Prior entries October, 1934; February, 1935; July, 1936.)

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Bequest Forms: Unto the California Medical Association*

FORM OF CLAUSE OF WILL PROVIDING FOR CASH BEQUEST

I hereby give and bequeath unto Trustees Of The California Medical Association, a nonprofit corporation of California, the sum of $——— to be known as the ——— Gift, to be used and expended by said corporation for scientific, educational, or hospital purposes.

* * *

FORM OF CLAUSE OF WILL PROVIDING FOR CASH BEQUEST

I give and bequeath unto Trustees Of The California Medical Association, a nonprofit corporation of California, the sum of $———, to be held as a fund, to be known as the [here insert name desired] Fund, the principal whereof shall from time to time be invested to the best advantage compatible with safety, and the income whereof shall be used and applied for scientific, educational, or hospital purposes.

* * *

FORM OF CLAUSE OF WILL PROVIDING FOR BEQUEST OF PERSONAL PROPERTY

I give and bequeath unto Trustees Of The California Medical Association, a nonprofit corporation of California [here describe the property], the same, or the proceeds thereof, to be held as a perpetual fund, to be known as the [here insert name desired] Fund, the income whereof shall be used and applied for scientific, educational, or hospital purposes. The said corporation shall have the power to sell said property and to invest and reinvest the proceeds arising from the sale thereof from time to time as it may deem advisable for the purpose of producing as large an income as may be compatible with safety.

* * *

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I give and devise unto Trustees Of The California Medical Association, a nonprofit corporation of California, to aid and further its scientific, educational, and hospital purposes, and to be known as the ——— Gift, the following described real property situate in the County of ———, State of California, and more particularly described as follows, to wit:

* * *

FORM OF CLAUSE OF WILL PROVIDING FOR DEVISE OF REAL PROPERTY

I give and devise unto Trustees Of The California Medical Association, a nonprofit corporation of California [here describe the property], the same, or the proceeds thereof, to be held as a perpetual fund, to be known as the [here insert name desired] Fund, the income whereof shall be used for and applied to the support and maintenance of scientific, educational, or hospital purposes. The said corporation shall have the power to sell said property and to invest and reinvest the proceeds arising from the sale thereof from time to time as it may deem advisable for the purpose of producing as large an income as may be compatible with safety.

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* These Bequest Forms were discussed editorially in CALIFORNIA AND WESTERN MEDICINE, for March, 1936, p. 145, and June, 1936, p. 460.

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OFFICIAL JOURNAL OF THE CALIFORNIA MEDICAL ASSOCIATION

VOL. 50 JANUARY, 1939 NO. 1

California and Western Medicine
Owned and Published by the
CALIFORNIA MEDICAL ASSOCIATION
Four Fifty Sutter, Room 2004, San Francisco, Phone DOuglas 0062

Address editorial, business and advertising communications to Dr. George H. Kress as per address above.

EDITOR . . . . GEORGE H. KRESS

Advertisements.—The Journal is published on the seventh of the month. Advertising copy must be received not later than the fifteenth of the month preceding issue. Advertising rates will be sent on request.

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Subscription prices, $5 ($6 for foreign countries); single copies, 50 cents.

Volumes begin with the first of January and the first of July. Subscriptions may commence at any time.

Change of Address.—Request for change of address should give both the old and the new address. No change in any address on the mailing list will be made until such change is requested by county secretaries or by the member concerned.

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Contributions—Exclusive Publication.—Articles are accepted for publication on condition that they are contributed solely to this Journal. New copy must be sent to the editorial office not later than the fifteenth day of the month preceding the date of publication.

Contributions—Length of Articles: Extra Costs.—Original articles should not exceed three and one-half pages in length. Authors who wish articles of greater length printed must pay extra costs involved. Illustrations in excess of amount allowed by the Council are also extra.

Leaflet Regarding Rules of Publication.—CALIFORNIA AND WESTERN MEDICINE has prepared a leaflet explaining its rules regarding publication. This leaflet gives suggestions on the preparation of manuscripts and of illustrations. It is suggested that contributors to this Journal write to its office requesting a copy of this leaflet.

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EDITORIALS†

"CALIFORNIA PHYSICIANS SERVICE"—A STATE-WIDE MEDICAL SERVICE PLAN: AUTHORIZED BY THE CALIFORNIA MEDICAL ASSOCIATION

"California Physicians Service."—"Proposed Voluntary Medical Service Plan" was the caption to some editorial comment which appeared on page 426 of the December, 1938, issue of the OFFICIAL JOURNAL. The call for a special session of the California Medical Association House of Delegates was made known on page 470, and references to other articles were given in a footnote.

The House of Delegates convened in Los Angeles on Saturday, December 17, continuing its two days' session through Sunday afternoon, the 18th. By a vote of 114 delegates in favor and 12 votes against, the House of Delegates, as the supreme body in the California Medical Association, acting through delegates who were the representatives of the component county societies, went on record as favoring the institution of a voluntary medical service organization, to be known as the "California Physicians Service." The necessary enabling resolutions and instructions to the Council, authorizing the latter group to proceed with the skeleton plans that had been presented, were adopted by the House, with definite majorities.

The Council and its Special Committee, therefore, will continue along the lines laid down in the plans there submitted to the House by the Council on December 17 and 18. The Council will hold its next meeting on Saturday, January 14, to consider and act upon progress reports then to be presented. Suggestions from members are cordially invited.

* * *

A Nonprofit Medical Service Plan: Some of Its Provisions.—It is still too early to convey much information of a final nature on the details of this epoch-making plan, but it is hoped that, in the February issue of CALIFORNIA AND WESTERN MEDICINE, or through a separate brochure, a fairly complete report will be available for members of the California Medical Association. In the meantime, it may be well to keep in mind that the tentative plans contemplate inclusions such as the following:

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† Editorials on subjects of scientific and clinical interest, contributed by members of the California Medical Association, are printed in the Editorial Comment column which follows.

A medical service, with hospitalization, of statewide scope; but a service instituted through local or regional units, such as counties or districts, in which due recognition will be given to environmental factors obtaining in the areas involved. The extent to which the physicians in each region express their desire to coöperate will be determining elements in the selection of the districts where the plans will first be put into active operation.

Every physician possessing the degree of Doctor of Medicine and having a valid certificate from the Board of Medical Examiners of the State of California, may make application to be listed as a "professional member" of "California Physicians Service," the name which will probably be given to this new nonprofit medical-service corporation. The proposed organization, therefore, will in no sense be a closed corporation.

The incorporators, for purposes of convenience, will be the present members of the Council of the California Medical Association. The incorporators will become the first administrative members. The first board of trustees will be designated in the articles of incorporation, as is required by law, and will be certain of the members of the California Medical Association as yet to be designated by the Council. When the terms of the first trustees expire, the administrative members will elect their successors. As soon as possible after incorporation, the incorporators will resign as administrative members and be replaced by administrative members elected by the membership of the County Medical Societies from geographical districts.

Professional members will pay a certification fee of five dollars at the time when application for such membership is made. The House of Delegates authorized the Council to loan the new corporation a sum up to fifteen thousand dollars, to cover expenses incidental to putting the plan into operation.

The citizens of certain income groups (the classes still to be decided), who wish to secure for themselves medical service on a periodic payment basis, and who make application, will be known as "beneficiary members." Monthly or other periodic payments received from beneficiary members will be under the custodianship of the board of trustees of the nonprofit medical service association and the board of trustees will be required to set aside a certain portion thereof as a permanent reserve fund to meet emergencies, and another portion thereof to cover necessary administration expenses, this to be kept as low as possible, the remainder to be used to pay professional members and hospitals for services previously rendered.

The payments to the physicians who are registered as professional members and who have submitted statements for professional services rendered to beneficiaries, will be on the unit basis. The "unit" and the frequency of such payments, *i. e.*, whether monthly, quarterly, etc., are still to be determined.

Adequate Medical Service of Proper Standard Will Be Available Through This Plan.—It would be possible to continue at great length, giving details such as the above, but, at this time, it is not necessary. Suffice it to say, that this nonprofit medical service organization will come into corporate being in the not distant future, as one that aims to give medical service of highest standard, to those citizens of California who, under present-day conditions of living, find it an increasing hardship, and at times an impossibility, to meet the expenses incident to unforeseen and unpredictable illness.

It is to be remembered that many of the citizens in the groups under consideration have found it impossible for some time past properly to recompense physicians for the professional services that have been rendered. If the California Physicians Service, therefore, can place in operation a medical service plan with a big mass spread, then it should be equally possible for a large number of citizens to receive adequate medical care at a cost so comparatively low as to be quite within their means, at the same time making it feasible for the physicians, who generously render the aid, to receive in payment, cash, and in amount, as great, or perhaps more than that they receive by and large, under present conditions.

* * *

Other Articles in This Issue of the Official Journal.—On other pages* in this issue will be found additional articles and reports, with newspaper editorials and press items which appeared when the action taken by the California Medical Association through its House of Delegates was first made public; and all these are commended to the consideration of readers of the OFFICIAL JOURNAL. In the February issue also, more detailed information will be presented. In the meantime members of the California Medical Association who have not paid much attention to these problems of medical service to certain income groups, or who have not kept in touch with recent reports appearing in the OFFICIAL JOURNAL, are requested to withhold their judgment of the proposed plans until they have had opportunity carefully to look over and study the final plans for inauguration of the service.

ANNUAL SESSION PAPERS, EXHIBITS, AND FILMS

Information Concerning Scientific Papers, Exhibits, and Films.—On January 8, the annual joint meeting of the California Medical Association Committee on Scientific Work and the secretaries of the twelve scientific sessions of the Association will have been held, and the general nature of this year's coming annual session programs outlined.

The attention of prospective essayists, therefore, who have not yet done so, is called to the importance of immediate communication with the proper Section Secretaries concerning submission of articles they have in mind.

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* For additional information on matters here commented upon, see pages 35–48.

Members who also desire to present exhibits or films should write to the Association Secretary, giving all helpful information about them. Those who have had films made on medical and surgical studies will do well to send to the Committee* the necessary data, so that arrangements may be made, if possible, for proper allocation of exhibit space or for presentation in the cinema booth, on certain days and at definite hours, of the photographs available. Prompt coöperation in these matters will be appreciated, since it will aid in making the 1939 annual session, to be held at Del Monte on May 1-4, one of the most profitable and enjoyable of all series of meetings.

Finally, members are urged to make their plans now for attendance, since problems of vital importance to medical practice in California will come up for serious consideration.

ON GRAND JURY INTERPRETATIONS OF MEDICAL ETHICS

Laymen Find It Difficult to Interpret Professional Ethics.—Physicians often find it difficult to explain to themselves the seeming incapacity of many of the laity and their organizations to understand why it is necessary for the medical profession, in its efforts to promote and maintain proper medical and hospitalization standards, to lay down very definite rules for its disciples and their institutions.

Come now, recently, some of the governmental agencies, in different sections of the country, who so misinterpret the basic reasons for the qualifications and restrictions of membership in county medical societies and on hospital staffs, that the federal antitrust laws are brought forward to make demands for changes that are little else than trade rules for admittance to membership.

* * *

County Society Membership.—Consider, first, this matter of membership, in a component county medical society. Physicians are part of a learned profession which, through its own efforts and at great effort, in most commonwealths of the Union has been able to have inserted into many state medical practice acts, educational qualifications in harmony with those maintained by the approved medical schools of the United States. To do this, however, has meant recurrent battles in almost every legislative session. Take, for example, our own State of California: from the very beginning, we have been forced to give battle to those who would lower those standards of professional training, so necessary to observe and live up to, if the public health is to be properly safeguarded.

Each of the component county societies, that make up the California Medical Association, accepts only those physicians who have had qualifications that permitted them to take and pass an examination by the Board of Medical Examiners of the State of California. But more than that is really necessary because, in one sense, a component county medical society can do its work to best advantage, provided its members have not only the educational background of proper standards, but possess also other attributes that make them harmonious and desirable units in the organization.

Physicians are an educated group of citizens, and they do not find it advantageous, for professional advancement or pleasant fellowship, to be associated with persons of deficient professional attainments, or who, because of certain character or temperamental attributes, are uncongenial. Such individuals have the right to practice the healing art, in so far as laws give them authority, but they certainly have no right legally to demand admission to membership in an organization in which harmonious outlook on mutual scientific, economic and other problems is necessary, if the organization is to do its work to best advantage. Likewise, as in similar organizations, when an individual who has been admitted engages in activities out of harmony with the organization, he might well resign. It is not to be wondered at, under such conditions, that steps have been taken to secure expulsion from membership, when violation of constitution and by-laws has been demonstrated on the part of such individuals.

* * *

Hospital Staffs.—So also as regards hospital staffs. The modern-day standards of hospital practice were voluntarily brought into being by physicians, in conjunction with the Council on Medical Education and Hospitals of the American Medical Association and of the American College of Surgeons. In hospital practice there is a very intimate personal association between members of a learned profession. The hospital also represents a certain amount of capital investment and, in proportion as it has a staff of harmonious attending physicians and surgeons, is able to that degree to give a better type of service to the patients who seek admission. Physicians who are inharmonious elements, as staff members of high standard hospitals, are not prevented from taking their patients to other hospitals. They are simply denied the right to lower the tone and service of hospitals, whose attending staffs look upon them as uncongenial elements. Such individuals should ask themselves the question: What is wrong with me? and what am I doing that makes other physicians wish to avoid intimate professional affiliation with me?

* * *

Advent of the Antitrust Law Argument.—Thoughts such as the above could be elaborated, did space permit. It is strange, in one sense, that there should now come, at the special instance of certain members of the legal profession, the promulgation of the doctrine, that the rules which physicians have laid down for themselves, in their efforts to provide high educational and other standards for medical licensure and hospital staff membership, are one and the same, with certain provisions on the statute books, placed there in years gone by, and designed to prevent restraint in trade; and that demand is now made that these practices of a learned profession, of such excellent purpose, must be discontinued because they are a violation of the trade antitrust laws!

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* Names of the State Committee appear in the roster on advertising page 2; and of Section secretaries on advertising page 6.

It will be interesting to note the outcome of some of these recent events, so prominently colored in the generous publicity that has been given thereto. Here also, it may be well to wait and see.*

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* Apropos of the above, the attention of readers is directed to some press clippings which appear in this issue, on pages 70–74.

POSTGRADUATE CLINICAL CONFERENCES

Tentative Plans for Spring Postgraduate Conferences.—In previous issues of California and Western Medicine attention was called to the postgraduate brochure which appeared as a supplement to the October issue of California and Western Medicine. The subject is again brought forward as a reminder to component county societies to appoint local committees on postgraduate courses, with whom the California Medical Association Committee on Postgraduate Activities, in proper time, may correspond, when itineraries of the visiting speakers and clinicians are being formulated.

A tentative plan, now under consideration, contemplates the formation of a number of visiting teams, one for the northern counties, one for the central valley region, and a third for the southern portion of the state. If proper coöperation is given, it may be possible to have a different team go out, once each month for, say, a series of three months, holding one or two-day clinics in several cities, each team making its circuit in about one week, whereby each month a different group of topics would be presented. Such a series of meetings could be made of great interest and real value.

Program committees of county societies are requested to keep these plans in mind. With proper coöperation it should be possible to at least try out these proposals. Correspondence with the Association Secretary, who is also the secretary of the Committee on Postgraduate Activities, is invited.

Other State Association and Component County Society News.—Additional news concerning the activities and work of the California Medical Association and its component county medical societies is printed in this issue, commencing on page 35.

The selection of activities to be carried on within each state has been left largely to the state health departments. Each state health officer has the privilege of originating such plans as he may consider best for his state. While these plans must be submitted to the Public Health Service for approval before they become effective and before the payment of federal funds may be made, it has been the policy of the Public Health Service to give its approval to any plan that may be considered scientifically sound and which gives promise of an adequate return on the investment.—C. E. Waller, United States Public Health Service.

EDITORIAL COMMENT†

THE IDENTIFICATION OF FUNGI CAUSING DISEASE IN CALIFORNIA *‡

Molds play a definite rôle in the production of disease and, in recent years, have received increased recognition. This is particularly true in California, where the incidence of Coccidioidal infection directs attention to pathogenic fungi. The symptoms and signs of fungous diseases are complex and beyond the scope of this paper. There are, however, certain biologic aspects of fungous diseases that merit attention. These aspects are not only interesting from the standpoint of biology, but they raise questions that are of practical importance to the physician and to the public health official. Considering Coccidioidal granuloma specifically, but with fungous diseases generally in mind, there are three questions to which your attention is directed:

First: How are the infections acquired, and how do the organisms maintain themselves?

Second: How do the fungi behave in culture solutions, as compared with other type of pathogenic organisms?

Third: How reliable are skin tests, complement-fixation reactions or other serologic procedures for diagnosis?

Considering the first question: How are infections acquired? Practically all infections are chance infections. We do not see epidemics of fungous diseases as we do in microbian and virus infections. The microbian and virus diseases maintain themselves through the agency of hosts or infection chains. Tetanus and botulism, however, are exceptions to this rule. The agents of fungous diseases are not true parasites, but are "pathogenic saprophytes." The possible exceptions to this are the dermatophytes. The infectiousness that is characteristic of a true parasite is lacking—especially with Coccidioides immitis. There are over five hundred cases of Coccidioidal granuloma on record in the State of California since 1894: *None* of these cases has been traced to a preëxisting infection. The ability of Coccidioides immitis to exist and to multiply in the inanimate world is fully developed, and this fungus may be found in the soil of the regions where the disease is most prevalent.[1] Coccidioides grows and flourishes on grass, potatoes, carrots, cactus, and on pieces of decayed wood. Such an organism must be widespread and

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† This department of California and Western Medicine presents editorial comments by contributing members on items of medical progress, science and practice, and on topics from recent medical books or journals. An invitation is extended to all members of the California Medical Association to submit brief editorial discussions suitable for publication in this department. No presentation should be over five hundred words in length.

* From the Departments of Medicine and Dermatology, University of California Hospital, University of California, San Francisco.

Read before the General Medicine Section of the California Medical Association at the sixty-seventh annual session, Pasadena, May 9–12, 1938.

‡ The writer wishes to express his appreciation for the help and suggestions given him by Dr. W. J. Kerr, professor of medicine, University of California Hospital, San Francisco, and by Dr. K. F. Meyer, director of the George Williams Hooper Foundation for Medical Research, University of California, San Francisco.

[1] Stewart and Meyer: Proc. Soc. Exper. Biol. and Med., 29:937, 1932.

METABOLISM OF MOLDS COMPARED WITH OTHER TYPES OF PATHOGENS

	SUGAR FREE			SUGAR PRESENT			
	PH	AMMONIA	VOLATILE ACIDS	PH	AMMONIA	VOLATILE ACIDS	GLUCOSE
B. TYPHOSUM (Kendall)[2]	⇡	⇡	⇡	⇣	⇡	⇡	⇣
LEISHMANIA TROPICA (Salle)[3]	⇡	⇡	⇡	⇣	⇡	⇡	⇣
ACTINOMYCES BOVIS (Stewart)[4]	⇡	⇡	⇡	⇣	⇡	⇡	⇣
COCCIDIOIDES IMMITIS (Stewart and Meyer)[5]	⇡	⇡	⇣	↑	↑	↓	↓
BLASTOMYCES DERMATITIDIS (Stewart and Meyer)[5]	⇡	⇡	⇣	↑	↑	↓	↓
TRICHOPHYTON INTERDIGITALE (Goddard)[6]	⇡	⇡	⇣	↑	↑	↓	↓

Arrows pointing up = increased value of partition
Arrows pointing down = decreased value of partition

the portals of entry into the animal tissues are numerous. When this organism gains entrance into animal tissues it may behave like a true parasite. What conditions or what factors bring about this change? Within the answer to this particular question may lie the possible explanation of the pathogenesis of Coccidioidal granuloma and other fungous diseases.

How do fungi behave in culture solution when compared with other types of pathogenic organisms?

The answer to this question is best shown by comparing the metabolism of three pathogenic molds with the metabolism of a Bacterium, a Protozoan, and an Actinomycete. Metabolism studies have been carried out on all of these types by various investigators. It is important to remember that all of the investigators used the same biochemical methods and the procedures followed in the analyses were almost identical. Each investigator used media rich in protein or nitrogenous material, and the metabolism of each organism was studied in the presence of glucose and in the absence of sugar. This procedure demonstrated the effect that the consumption of glucose had upon the protein metabolism. The table presented has been prepared from data obtained from the original reports of the different investigators. The actual numerical values are omitted, and arrows are substituted so that the *direction* of the metabolic changes may be clearly indicated. Arrows pointing upward and downward are used to show the rise and fall in the values of the fractions given. Solid or black arrows are used for emphasis and to draw attention to the molds. Only four of the usual partitions that are studied in metabolic experiments are given. This is in the interest of clarity, and the essential differences are seen in these four fractions. Full numerical values for all partitions, such as amino-nitrogen, polypeptid nitrogen, etc., may be found by consulting the original reports where full discussions of methods, procedures, and interpretations are set forth.

All of the organisms are well-known pathogens. The names of those who conducted the original investigations are given in parentheses. Let us compare the metabolism of these different types of organisms first, when no sugar is present in the medium and, second, when glucose has been added.

Metabolism in the Absence of Glucose.—The metabolic activity is marked by an increase in the degree of alkalinity and also by the amount of ammonia produced. This is true for all types. The volatile acids decrease in the case of the molds—probably because these compounds serve as satisfactory sources for carbon.

Metabolism in the Presence of Glucose.—Here the metabolism is seen to differ in the case of the molds from all of the other types. It is important to notice that all organisms consume glucose—this is shown by downward direction of the arrows. The utilization of glucose by the fungi does not produce an acid medium, as it does in the case of the other types. The values for volatile acids again fall during the growth of the molds, but rise in the other types. These differences cannot be overemphasized. They prove that molds do not metabolize their nutrients—especially glucose—as do the bacteria. Additional experiments in the metabolism of Coccidioides immitis and Blastomyces dermatitidis have shown that the *composition* of the medium determines the final acidity or alkalinity and *not* the utilization of glucose. This observation invalidates the customary procedure for the identification of molds by sugar reactions. In such methods various sugars are incorporated into media and an indicator is added, after adjusting the medium to a definite p^H. When the indicator shows that acid is present, we have assumed that this is synonymous with sugar consumption and our reports have been so recorded.

To complicate the situation even more, definite evidence exists that the composition of the medium determines the color, form and texture of the molds.[7] Dowding and Orr[8] have shown that no correlation can be made between the clinical types of "ringworm" and the character of the mold isolated and grown on Sabouraud's medium. The influence of slight changes in the culture solutions has an effect upon fungi that exceeds any that we are accustomed to see in the field of bacteriology. It is not possible to control the variations in the commercial peptones and meat extracts that form the bases for the usual culture solutions. It is little wonder, then, that there is confusion in the literature dealing with medical mycology. Chemically defined culture solutions, not necessarily inorganic, offer the best type of media. Such media can be duplicated anywhere, and provide a common standard of environment to which physiologic activity and morphologic description can be referred. To continue the use of bacteriologic procedures for cultivation of molds will add to and prolong the existing confusion.

Finally, we come to the consideration of the third question, and this concerns the reliablity of skin tests, complement-fixation reactions and other serologic procedures. The fungi again refuse to abide by the rules and create further problems for the immunologist. The present state of affairs may be summarized by saying that the *specificity* of serologic reactions remains to be proved, and that the *reliability* of serologic procedures has not been adequately demonstrated. In California we are particularly interested in the "skin test" for the diagnosis of Coccidioidal infection. Recent experimental work at the University of California indicates that all is not well with this test. Patients who have been proved to have Coccidioidal granuloma by culture, by animal inoculation and by pathologic examination, have repeatedly failed to give positive skin reactions with standard preparations of Coccidioidin, while other patients have given positive reactions with the same preparations. Guinea pigs have been inoculated with different cultures or strains of Coccidioides, and antigens have been made from these cultures. All animals have died with the typical lesions of Coccidioidal granuloma. The striking result has been that positive skin tests were obtained in these animals only when they received injections of coccidioidin made from the particular strain with which they were infected. Some cross reactions did occur, but they were mild and transitory. This suggests that we must use polyvalent antigens in making our tests. But the question immediately arises, "How many strains must be put into the antigen?" That question cannot be answered until we know how many strains of Coccidioides there are and what cross reactions take place.

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[2] Kendall: Jour. Infec. Dis., 30:211, 1922.

[3] Salle: Jour. Infec. Dis., 43:378, 1928.

[4] Stewart: To be published.

[5] Stewart and Meyer: Jour. Infect. Dis., 63:196, 1938.

[6] Goddard: Jour. Infec. Dis., 54:149, 1934.

[7] Emmons: Arch. Dermat. and Syph., 25:987, 1932.

[8] Dowding and Orr: Brit. Jour. Dermat. and Syph., 48:298, 1937.

After considering the three questions that have been raised, we arrive at this conclusion: Molds play their own game according to their own rules, and we have not yet learned how to "play ball" with them.

University of California Hospital.

Robert A. Stewart,
San Francisco.

SCHOOL PHYSICAL EXAMINATIONS

Discovery of Defects Not the Only Value of the School Physical Examination.—It is too often assumed that the detection of physical defects is the only objective of the periodic examination of school children. Undoubtedly, this is one of the most valuable features of this procedure, and when the discovery of defects is promptly followed by measures for correction, an immense amount of good is accomplished.

School Physical Examination of Value as a Health-Education Experience.—There are, however, many other values inherent in this examination. The physical examination of school children by a school physician is health-education experience of major importance. In the first place, a favorable attitude is developed toward the fundamental idea of having one's health appraised by competent physicians at regular intervals. The dental profession has made commendable progress in educating the public to prevent dental trouble by consulting the family dentist at regular intervals. One of the next great steps forward in preventive medicine will be made when the public are brought to realize that a periodic check-up of nutrition, heart, lungs, kidneys, etc., by the family physician is just as important as the biannual visit to the dentist.

In the second place, favorable attitudes toward health itself may be established. The school physician does not merely point out the defects which are discovered, but rather commends the fine points in the physique of the child who is being examined. Very often a small spark of self-respect is thus fanned into a glowing purpose to achieve optimum health. Many physical imperfections, especially those that result from faulty health habits, may be corrected by presenting to the child a health ideal, and describing in simple terms the road by which this ideal may be attained. In the physical examinations of school children the school physician has the advantage over all other school health workers, inasmuch as he is a doctor and as such speaks with authority on health matters. Even as early as the kindergarten age most children have been conditioned to accept the authority of physicians on matters of health. This creates a great opportunity and a great responsibility.

The Carry-Over Value of the School Physical Examination.—In recent years our school program is being evaluated on the basis of its carry-over value into adult life. The public are asking, "Are the school educational experiences fitting our young people to step out into life and meet its challenges?" The school physical examination is educating our children to keep their bodies fit by living in accordance with the laws of health and by seeking advice at regular intervals from competent physicians and dentists. This is "carry-over" of an enduring character.

School Examinations Help to Indicate Health Values of the School Program.—Furthermore, as Chenoweth and Selkirk have recently pointed out, "even though competent service is given some children by personal physicians, the school examinations are still of value in giving a picture of the health of the school as a whole, and in showing the effect of the school program for good or ill. They may indicate the need for radical reforms in such matters as hours of attendance, periods of rest and relaxation, the school midday meal, the amount of home work, and other parts of the program."[1] The other parts of the program referred to above might well include the physical education program. The physical examination of school children, if adequately performed, should provide information as to the soundness of these activities. Are we placing the emphasis on the right type of activity? Are the present basketball rules resulting in a game which is too strenuous for the adolescent boy? Are too much time and effort being devoted to football? Would emphasis on other athletic activities have greater health values? Help in solving these problems should be obtained from careful physical examinations by skilled school physicians.

The Function of the School Physician Is Health Supervision and Health Education.—School physicians are sometimes criticized for not making definite diagnoses in connection with obscure conditions affecting school children. The public forgets that private physicians in similar cases only make a diagnosis after a complete physical examination, together with most exhaustive laboratory investigations. School physicians, from the nature of their work and experience, become expert in observing the normal growth and development of children. They are alert to detect slight deviations from normal, the earliest symptoms of physical abnormality or disease. In such cases only time or the complete laboratory service at the disposal of the family physician or clinic will elucidate the diagnosis. The school physician is not in the school to take the place of either the family physician or the clinic physician; he is there to guide the children along the road to health. Along this road the family physician and dentist are exceedingly important in providing personal supervision of health and physical rehabilitation by treatment when necessary.

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[1] Chenoweth and Selkirk: School Health Problems, p. 154. F. S. Crofts & Co., Inc., New York, 1937.

Chenoweth and Selkirk have admirably analyzed the situation as follows: "The school examination aims not at making diagnoses, but at pointing out the need for medical supervision when necessary. Its purpose is not to provide advice as to treatment even for the indigent class, since this consumes too great an amount of time and is more efficiently handled by other means. The health examination is essentially an effort in health education to establish suitable attitudes in the child and his parents, and to act as a motivating force for healthful living. By the school examination, however, masses of children are examined who would otherwise be passed by, a multitude of defects are discovered which would otherwise pass unnoted, and correction is instituted in vast numbers of cases."[2]

Physical Findings of Physicians of Value to the Classroom Teacher.—A great deal of the value of the school physical examination may be lost if the information obtained by the school physician is not made available to the teachers. Every effort should be made through health coördinators, or someone functioning in that capacity, to see that the findings of the school physicians are passed on to the classroom teacher. Defects of vision, hearing, heart, and malnutrition, etc., create classroom situations and problems which can only be handled intelligently when the information obtained by the physician is made available to the teachers.

Chamber of Commerce Building.
C. Morley Sellery,
Los Angeles.

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[2] Chenoweth and Selkirk: School Health Problems, p. 155. F. S. Crofts & Co., Inc., New York, 1937.

In these days, half our diseases come from the neglect of the body in the overwork of the brain. In this railway age the wear and tear of labor and intellect go on without pause or self-pity. We live longer than our forefathers; but we suffer more from a thousand artificial anxieties and cares. They fatigued only the muscles—we exhaust the finer strength of the nerves.—Bulwer.

With stupidity and sound digestion men may fret much; but what in these dull unimaginative days are the terrors of conscience to the diseases of the liver.—Carlyle.

ORIGINAL ARTICLES

PROBLEMS IN THE DIAGNOSIS OF ACUTE APPENDICITIS*

By Thomas O. Burger, M. D.
and
Harold C. Torbert, M. D.
San Diego

Discussion *by E. H. Eiskamp, M.D., Watsonville; John Homer Woolsey, M.D., Woodland.*

Failure to diagnose acute appendicitis promptly and correctly was the subject of the chairman's address by the senior author[1] before the Section on General Surgery of the California Medical Association in 1926. A review of 449 cases of acute appendicitis seen in our practice during the past ten years offers unhappy evidence that surgical intervention is still too often delayed by faulty diagnosis. The seriousness of a situation which results in high mortality rates during so recent a period indicates vividly the need for continued attention by the profession to this whole matter. It is our purpose, therefore, to review in some detail the results of our study of the ten-year case series, in the hope of pointing out some of the pitfalls actually encountered in day-to-day practice.

CLINICAL MATERIAL FOR THIS STUDY

Of the 449 cases, all but three were proved by histological examination. In the three exceptions, operation was limited to drainage of abscesses without removal of the ruptured appendix.

In 129 cases, or 26.9 per cent of the series, the appendix was ruptured at the time of operation. Thirty patients died, a mortality rate for the series of 6.7 per cent. Twenty-six of the thirty deaths occurred among the 129 patients with ruptured appendices, a mortality rate for this group of 20.2 per cent. Among 320 unruptured cases there were four deaths, a mortality rate of 1.25 per cent. Actually, only one of these four deaths, a case of pulmonary embolism occurring in a thirty-eight-year-old male, can fairly be attributed to the operation. The remaining three deaths were due to the following causes: Myocardial failure in a man, seventy-nine; cerebral hemorrhage in a woman, sixty-seven years old; and suicide on the tenth day of an uncomplicated postoperative course by a forty-six-year-old male. Nevertheless, taking the uncorrected figures as they stand, the contrast is impressive enough.

Obviously the referring physicians were not responsible for all delayed and ruptured cases. Too familiar is the patient who has been ill three, four, or more days before he calls his family doctor. Equally familiar is the patient, or family, who refuses surgery, or delays accepting it until many days have passed. Furthermore, there are cases in which the morbid process is so fulminating that the appendix ruptures before the promptest of diagnoses and intervention can take place.

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* Read before the General Surgery Section of the California Medical Association at the sixty-seventh annual session, Pasadena, May 9–12, 1938.

TABLE 1.—*Showing the Number of Patients Complaining of the Classical Symptoms of Acute Appendicitis*

Symptom	Number of Patients Presenting Symptom	Percentage of Total Number of Patients
Nausea	305	64.5
Vomiting	211	48.1
Epigastric discomfort	138	31.4
Generalized abdominal pain	250	56.9
Localized pain	408	92.9
Not stated	10	

RESPONSIBILITY OF THE PHYSICIAN

But after all cases of patient error have been eliminated, there remain such a large number of instances of delay or failure in diagnosis on the part of the physician as to constitute a serious challenge to every thoughtful medical man. As Monte Reid points out in a recent editorial published after this paper was prepared[2], responsibility must rest squarely on the shoulders of every medical man who temporizes with this disease, in view of the known striking difference in the mortality and morbidity of delayed, as contrasted with early operation. We say medical man advisedly, because, although surgeons are not free of error, it is usually the family doctor or internist who first sees the patient. Upon him, therefore, rests the primary responsibility of making the diagnosis, or at least of suspecting it, and obtaining adequate surgical advice.

SO-CALLED CLASSICAL SYMPTOMS

Every physician is familiar with the diagnostic constellation of generalized abdominal pain shifting to the right lower quadrant, with nausea, vomiting, point tenderness, muscle rigidity, moderate elevation of pulse rate and temperature, and increased leukocyte count, chiefly in the polymorphonuclear neutrophiles. However, the record seems to show that many are not familiar with the fact that, as Finney[3] puts it, "all of these things are present in a few cases, a few of them are present in the majority of cases, and virtually none of them are present in quite an appreciable number of cases." (Table 1.)

Table 1 shows that no single one of the so-called "classical" symptoms was present in every case. The most constant finding was localized pain, present in 92 per cent. Finney also found this to be one of the most consistently reliable symptoms. Tables 2 and 3 show the errors into which dependence on any single sign, such as fever or elevated blood count, will lead the diagnostician. Our records lead us to agree with other writers that a relative increase in polymorphonuclear neutrophiles is a more constant finding than is elevation of the total white count. Physical examination proved somewhat more reliable than either history or laboratory examination, 399, or 88.9 per cent of the cases exhibiting signs which were interpreted as positive for acute appendicitis. (Tables 2 and 3.)

TABLE 2.—*Showing the Temperature Found at the First Examination of the Patients*

Temperature in Degrees Fahrenheit	Number of Patients
Below 99.0	126
99.0 to 99.9	148
100.0 to 100.9	70
101.0 to 101.9	63
102.0 to 102.9	29
103.0 to 103.9	11
Above 104.0	2

TABLE 3.—*The Total White Blood Cell Count at First Examination of the Patients with Acute Appendicitis*

Total Leukocyte Count	Number of Patients
Below 11,000	125
11,001 to 15,000	111
15,001 to 18,000	70
Above 18,000	143

VARIATIONS IN THE COURSE

The need for alertness and freedom from preconceived ideas regarding the alleged typical onset of appendicitis is strikingly illustrated by Table 4, which lists the presenting symptom in some of the cases which had ruptured before surgery. In each of these cases, emphasis on the presenting symptom led to delay in making the correct diagnosis. The clinician should also bear in mind the cases reported by Mastin[4] in which pain was referred to the shoulder and clavicle. We did not happen to encounter this symptom in our series. (Table 4.)

TABLE 4.—*Unusual Presenting Symptoms Encountered in Our Series of Cases. In Each of These Cases, Emphasis on the Presenting Symptom Had Led to Delay in Making the Correct Diagnosis of Acute Appendicitis.*

Presenting Symptom	Number of Patients
Chill	2
Convulsion	2
Pain in right flank	11
Pain in right lumbar region	3
Pain in left upper quadrant	1
Pain simulating ureteral colic	1
Pain in testicle	1
Dysuria	6
Urinary frequency	3
Pain along outer surface of thigh	1
"Gas" and belching	4
Severe diarrhea	5
Obstinate constipation	2
Anorexia	1

TABLE 5.—*Location of the Appendix in the Patients of This Series. It Should Be Observed that by No Means All the Appendices Listed in the Right Iliac Fossa Were Found Even Approximately Under the Point Described by McBurney. The Three Listed as of Unknown Location Occurred in Patients in Whom Operation Was Limited to Drainage of Appendiceal Abscesses.*

Location of the Appendix	Number of Patients
Right iliac fossa	300
Retrocecal	119
Pelvic	22
Right upper quadrant of abdomen	1
Left upper quadrant of abdomen	1
Sac of right inguinal hernia	3
Unknown	3

A fertile source of error is the complaint of pain and the finding of tenderness at points other than in the right lower quadrant. Pain and point tenderness may occur over the inflamed appendix, wherever it lies—and the appendix may be found in many places within the abdomen other than directly under the point described by McBurney, and even outside of the abdomen, in hernial sacs. In one of our cases, the pain and point tenderness were in the upper left quadrant, and so was the gangrenous appendix. In three others, acutely-inflamed appendices were found in the sacs of right inguinal hernias, two in infants and one in an elderly woman. We have discussed the problem of hernial appendicitis elsewhere[5]. It is enough to say here that this diagnosis must be thought of in every case of supposedly strangulated hernia, especially if the symptoms are in any respect atypical. (Table 5.)

The retrocecal and the pelvic appendix are other traps for the unwary. The former may initiate symptoms likely to be confused with disease of the kidney, ureter, gall bladder, or thoracic organs. Soreness in the right flank, or even the right costovertebral angle, is the only sign in not a few cases where the eppendix lies behind the cecum. At times, especially in the obese subject, there will be an almost total absence of physical findings. In such cases one should be on the lookout for an inflamed appendix nestling under the protection of a thick, fatty omentum, either behind or at the side of the cecum. The inflamed pelvic appendix may be overlooked entirely, or it may be confused with disease of the ureter, bladder or genital organs. In many of these cases, diarrhea and rectal tenesmus will be the only complaints. It is shocking to note, when studying a group of histories, how frequently rectal examination is omitted. This simple procedure frequently elicits the only objective sign of an inflamed pelvic appendix. Rectal examination should never be omitted in any patient with an abdominal complaint, or indeed in *any* physical examination. In this connection a study of Brunn's[6] paper is recommended. (Table 6.)

TABLE 6.—*Distribution of the Patients with Acute Appendicitis According to Age and Sex*

	Age in Years									
Sex	0-9	10-19	20-29	30-39	40-49	50-59	60-69	70-79	80-89	Unknown
Male	20	51	45	17	24	19	12	8	0	6
Female	18	70	72	22	22	12	10	10	1	0
Total	38	121	117	49	46	31	22	18	1	6

INCIDENCE ACCORDING TO SEX

Although acute appendicitis is said to occur more frequently in males, our series agrees with that of Sengstacken[7] in showing a slight majority of females. . There were 237 females and 212 males. Despite the fact that disease of the female pelvic organs offers greater opportunity for confusion in diagnosis, a larger number of the ruptured cases occurred in males, the proportion being 31.6 and 24.9 per cent respectively for males and females. (Table 7.)

AGE INCIDENCE

While it is true that acute appendicitis occurs most frequently in persons between the ages of ten and thirty years, no period of life is exempt. There were eleven females and eight males past seventy years of age in this series. All the females and five of the males had ruptured appendices. It is admittedly more difficult to make the diagnosis in the elderly. Often the onset is subacute. Pain, nausea

TABLE 7.—*Distribution of the Patients with Ruptured Appendices According to Age and Sex*

	Age in Years									
Sex	0-9	10-19	20-29	30-39	40-49	50-59	60-69	70-79	80-89	Unknown
Male	7	15	11	7	8	12	4	5	0	1
Female	11	10	6	7	5	5	4	10	1	0
Total	18	25	17	14	13	17	8	15	1	1

and vomiting, and rigidity are frequently absent. In many cases there are only generalized abdominal soreness and increasing constipation. Elderly patients frequently do not show the typical leukocytic response to infection, or any marked rise in temperature. Too frequently, signs of general peritonitis or a localized abscess give the first clue to the nature of the illness. Lazarus[8] is one of the recent writers to discuss this problem.

The young child also may tax the skill of the most capable diagnostician. Maes and coworkers[9] found that only 27 per cent of 250 children with appendicitis entered the hospital with their disease in the simple acute or acute suppurative stages. In our series there were thirty-eight children under ten, twenty boys and eighteen girls. In seven of the boys and eleven of the girls rupture had occurred. Two of our children had convulsions at the onset. In two others a violent chill was the initial symptom. Anorexia, colicky pains occurring intermittently and not localizing until very late, diarrhea, and general irritability, were other ways in which the infection was first manifested. We twice encountered temperatures above 104 degrees Fahrenheit. Leukocyte counts above 20,000 were not uncommon. Nixon and Nixon[10] and McClure[11] discuss the diagnosis of juvenile appendicitis and its special problems.

OTHER FACTORS

McKenna[12] emphasizes the importance of obtaining a sequential history in all cases of intra-abdominal disease. He also calls attention to Wilkie's belief that obstructive appendicitis is usually initiated by violent cramps, followed by nausea, vomiting, and repeated colicky attacks, whereas the acute inflammatory type most frequently has its onset with symptoms of malaise and without sharp pain. Such differentiation, however, is largely academic. Even if one could always be sure that the patient's symptoms were due to obstruction by a fecalith rather than to actual inflammation, it should be realized that the former is potentially just as dangerous. Indeed, perhaps a majority of ruptured appendices will show either a fecalith present, or signs of necrosis due to pressure by such a foreign body.

Although our records, especially in the earlier cases, do not contain notations regarding the presence or absence of skin tenderness in a sufficient number of cases to make it worth while to include this datum in the tables, we believe it to be a helpful finding in a certain percentage of cases. We agree with Livingston[13] that skin tenderness in the right lower quadrant will more frequently be elicited by vigorous stimulation than by the light stimulation used by Cope[14] and others.

AUTHORS' STATISTICS

It is no particular credit to us to have made a correct preoperative diagnosis in four hundred, or 89.1 per cent of the cases reported, and to have suspected the diagnosis strongly enough to operate for appendicitis in another thirty-three or 7.3 per cent, in view of the fact that so many of the patients were seen in consultation in advanced stages of the disease. The remaining 3.6 per cent, in which operation was performed under other diagnoses are instructive, however. In addition to the three cases thought to have strangulated hernias, another three patients were believed to have acute cholecystitis, two were thought to have salpingitis, two tuberculous abscesses, and two intestinal obstruction. One was diagnosed as having ruptured peptic ulcer, one a large ovarian cyst, one a tubal pregnancy, and one was at first believed to have colitis. In short, appendicitis may at times be confused with practically every acute disease within the abdomen.

IN CONCLUSION

In this connection we wish strongly to defend the diagnosis of "acute surgical abdomen," and the logically following exploratory operation. Skillful as the diagnostician may be, he will inevitably find an occasional case in which a specific diagnosis is not possible. It is rare, however, that he cannot in good conscience say that *something* is wrong in the belly. Too much time should not be lost in study or in waiting for definite localizing symptoms. Fewer deaths will result from occasional unnecessary laparotomies than from over-cautious delays which allow acutely inflamed appendices to rupture.

SUMMARY

1. A series of 449 consecutive cases of acute appendicitis is analyzed with respect to diagnostic problems.

2. The disease occurred in this series more frequently in females than in males. Although most common in the second and third decades, it was encountered in all age groups up to and including the ninth decade.

3. The percentage of cases ruptured when first seen by the surgeon was highest in the very young and very old, indicating the necessity for unusual care in studying abdominal complaints in these age groups.

4. No one symptom or sign occurred in every case.

5. Comparatively few patients showed the usual history of onset and physical findings described in the textbooks. Many exhibited some of the classical symptoms and signs. A surprisingly large number showed almost none of them.

6. Unusual symptoms of onset seen in this series included: chills, convulsions, dysuria, frequency of urination, pain resembling ureteral colic, pain in testicle, pain along outer surface of thigh, diarrhea and "gas."

7. The physician must not allow himself to be misled by atypical location of point tenderness and rigidity, or by their absence. These signs occur when peritoneum is irritated by an inflamed appendix, wherever it may lie—and the appendix may lie anywhere in the abdomen or even out of it, in a hernial sac.

8. Absence of point tenderness or rigidity should call to mind the possibility of a retrocecal or pelvic appendicitis.

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DISCUSSION

E. H. Eiskamp, M. D. (408 Main Street, Watsonville).—It has been a pleasure to discuss the paper of Doctors Burger and Torbert. It shows well-kept case histories and careful analysis of their findings, which are of great value to all of us. It is impossible to add anything to such a paper; however, there are certain things which I should like to emphasize.

I feel that in every patient with abdominal cramps without diarrhea the appendix must be eliminated, as it is the most common lesion of the intestinal tract. As one speaker stated, there is no one symptom or series of signs and symptoms necessary for the diagnosis of appendicitis, but we have felt the most important diagnostic point was midline abdominal cramps, followed by localized tenderness in the abdomen. The abdominal cramps may be high or low in the abdomen and may be referred to by the patient as cramps, gas, distress or aching, but he will usually state that moving or pressure does not aggravate them and often helps. After the localized tenderness arrives he may not recall them until he has been carefully questioned. The tenderness or soreness may be anywhere in the abdomen, depending on the location of the appendix. Regardless of the location of the tenderness, if preceded by abdominal cramps, we feel that we are probably dealing with an appendix. I feel that a rectal examination is of great importance, especially in children.

We feel that a pain beginning in the right side is probably not of appendiceal origin, unless a localized abscess of the appendix has ruptured, when careful history will usually tell of a preceding attack. Blood in urine is always a disturbing finding, but we have found it on some occasions. The white blood count is always very helpful if it shows a leukocytosis and an increase of polymorphonuclear, but is often absent, especially in fulminating appendicitis. We have found the Schilling index to be of some help in this type of case.

In the very early cases the appendix will appear normal to macroscopic examination, except for slight catarrhal inflammation of the mucosa at the point where it is kinked or a fecilith lies. If one is careful not to clamp the appendix itself, these early gross changes are not obscured.

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John Homer Woolsey, M. D. (Woodland).—Every statement in this paper is true, and discussion could well consist of the advice—study it, digest it, and do it. Failure to diagnose promptly and correctly is the physician's side of the problem. The opportunity for two or more able physicians to see the patient, as provided at a hospital or in group practice, does much to alleviate this. Consultation early and more often by the single practitioner is advisable. The classical history is not always present before surgical treatment, but after the patient is over the attack and he can think more logically, it is surprising how classical the history often becomes. Not infrequently we hear the opinion given, "He has appendicitis and we are watching him carefully." This is illogical thinking, for none of us can be certain of the stage of inflammation; and if the diagnosis is made, then for the safety of the patient, prompt and proper surgical care should be employed.

Pain is the common symptom and of greatest significance. In the elderly and the very young the nervous system is not as well organized and coördinated and the complaint may be not as classical. In the elderly the circulation is not as adequate and gangrene ensues much earlier. Fever is of no significance in relation to treatment. Never wait for fever before employing the only proper treatment—surgery. Local muscle spasm and tenderness is dependent to the main extent upon irritation of the parietal peritoneum and so an inflamed appendix entirely separated from the parietal peritoneum may have no muscle spasm and but little tenderness. The pelvic appendix is the most difficult type to recognize. As the author advises, read Brunn's excellent article. The white blood count is more misleading to the profession, as a whole, than any other index. Make your diagnosis before this information is at hand, and look upon it as an index as to the degree of protective response on the part of the patient.

Not every abdominal pain means appendicitis; but when the evidence is indicative of continued intra-abdominal inflammation act promptly, for a life is at stake. We do not recommend unnecessary or ill-advised surgery, but when the evidence is adequate prompt surgery is in order, and if necessary the preoperative diagnosis of "acute surgical abdomen" may at times have to be accepted.

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Doctor Burger (Closing)—In closing the discussion, I wish to thank all those who have participated. The contrast in mortality in this small group of cases was so marked that it seemed to us worth while to attempt to point out some of the pitfalls which led referring practitioners into delaying diagnosis until the appendix had ruptured.

May I repeat, a strikingly large number of ruptured appendices in our series occurred in very young and very old patients, and in persons where the organ was either retrocecal or protected by a large, fatty omentum. The physicians in very many of these cases failed to diagnose appendicitis "because there was no rigidity," or "no point tenderness at McBurney's point." Our tables are worth studying, and indicate how few cases showed all the findings of the so-called textbook picture. If the newer generations of doctors are ever to improve their diagnostic percentage in this disease, the picture embalmed in present-day surgical textbooks is going to have to be drastically modified, to conform more closely with the facts of real life.

Dr. Homer Woolsey's auscultation of the abdomen, which he so convincingly presented this afternoon, was not practiced by us in this series of cases, but he may be sure that we shall avail ourselves of this diagnostic aid in studying our next ten-year series of cases.

RADIATION THERAPY IN ACUTE AND CHRONIC INFLAMMATORY CONDITIONS*

By Henry Johnson Ullmann, M.D.
Santa Barbara

Discussion *by Robert S. Stone, M. D., San Francisco; Frederick H. Rodenbaugh, M. D., San Francisco; Orville N. Meland, M. D., Los Angeles.*

THE title of this paper is misleading, as the intention was to cover inflammations due to infections, since these are the conditions usually benefited by properly applied irradiation. Stress will be laid on the commoner forms seen almost daily in practice and in which irradiation produces immediate amelioration of symptoms and frequently a rapid cure. It is interesting to note that the treatment of inflammations and infections was one of the first uses of the roentgen ray in therapy; but although roentgen therapists have been familiar with its value and the literature is replete with reports, it is only within the last few years that its value has become recognized by the general profession.

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* Read before the Radiology Section of the California Medical Association at sixty-seventh annual session, Pasadena, May 9–12, 1938.

EXCERPTS FROM THE LITERATURE

The following quotations are taken from "A System of Instruction in X-Ray Methods" by S. H. Monell, M. D., 1902. These are given for their historical interest and to show how early the roentgen ray was found of benefit in the conditions under discussion.

"Stembo was led to make use of this method for the relief of neuralgic pains by the fact that sometimes patients report relief from pain when the rays have been employed for merely diagnostic purposes." I remember a patient in 1912 who obtained temporary relief from his sciatica, following the taking of pelvic roentgenograms. We all know the amount of radiation required to get a readable pelvic picture in those days. "Sittings were from three to ten minutes every second day. Relief was generally reported after the third application." "Schiff and Freund reporting four years' experience in August, 1900, consider furunculosis an indication for the use of x-ray." Monell devotes a whole chapter on the use of x-ray in tuberculosis and submits many case reports indicating its value.

"From Germany was reported the cure of a case of 'undoubted tuberculous peritonitis' by the x-rays," details followed.

There is no question that the value of irradiation in the treatment of tuberculosis, and some at least of the pyogenic infections have been known as long as its value in the treatment of acne, leukemia, eczema, psoriasis, and superficial skin malignancies; in short, from the time of its earliest use as a therapeutic agent. In spite of this knowledge, easily available in medical literature, there has been relatively little use of irradiation by the profession at large for these common affections until recent years, and even now its value is little appreciated away from medical centers.

DISEASES IN WHICH RADIATION IS OF PROVEN VALUE

Radiation is of proven value and in some cases the therapeutic agent of choice in:

Tuberculous adenitis, peritonitis, osteitis and arthritis, cystitis and seminal vesiculitis, and tuberculosis of the intestines and pelvis.

Mikulicz's Disease.—The roentgen ray has been used successfully in this condition for many years.

Chronic pharyngitis, especially with hyperplasia of lymphoid tissue following tonsil and adenoid operations in children, but is not sufficient to warrant another operation, and in the "smokers' or speakers' sore throat." The relief is distinct and definite.

Acute and subacute infections of the throat, especially the subacute with involvement of the regional lymph glands. Although the results are not uniform, they are enough to justify treatment in every such case.

Actinomycosis.—The reports are somewhat conflicting, but apparently the poor results were due to inadequate dosage. The dosage required for actinomycosis is apparently many times the optimum for the pyogenic infections and tuberculosis.

Furuncles.—It is well known to those who have treated a large number that, with few exceptions, a furuncle can be aborted in its early stages, especially before pus has appeared, by a single exposure to the roentgen ray. In the later stages, marked benefit is usually seen, but the results are not nearly so uniform or spectacular.

Pyodermias.—Usually streptococcic, about the nose and upper lip and all of great potential danger. I have treated a small but increasing number in the past few years with uniform and prompt healing as a result.

Carbuncles.—While not entirely uniform the results are usually spectacular. This effect is most noticeable in the slow indolent types, with little systemic reaction and marked toxemia. I consider irradiation of the spleen, in addition to the carbuncle, of considerable importance. This is partly on theoretical grounds, but I am under the impression that my results have been more prompt when this was done.

Benign Adenopathies of the Mediastinum and Lung Roots and Unresolved Pneumonias. — In these the effect is uniformly beneficial if the irradiation is properly carried out. In fact, there is no other treatment that offers so much. It is not possible to lay down any regular course or number of treatments. Each patient must be highly individualized and treatment carried out in close coöperation with the internist or pediatrician.

Chronic Sinusitis.—There are many favorable reports in the literature, but the author's experience has been limited.

Mild Chronic Inflammatory Processes Involving Limited Areas of the Lungs.—I admit this is a very loose description, but I refer to a condition in which the patient is more or less toxic, may or may not run a slight temperature at times, and in whom the internist can hear, at least occasionally, a few moist râles over a limited area. Sometimes the patient will have more or less discomfort referable to the same region. All search for a tuberculosis has rendered negative results. In the few such patients that I have irradiated over the affected lung area, the results have been very gratifying. The patients have uniformly felt and looked better, toxicity and temperature have disappeared, and weight gained. The effects have not been immediate. It has usually required two or three treatments a week for several weeks before really marked results were seen, although frequently the patients will say they feel better after the second or third dose.

Acute and Chronic Parotitis.—My experience has been limited, but results have been encouraging in the few treated.

Acute and Subacute Infections About the Jaws and Neck.—In these the effect of the irradiation is spectacular, as shown in the following typical cases, both referred to me by Dr. Barkley S. Wyckoff:

REPORT OF CASES

CASE 1.—A white male, age 37, entered the hospital February 24, 1938, with a history of fractured mandible for at least two weeks. This fracture proved to be a compound lesion into the mouth in the angle of the left mandible. Fracture was reduced and external drainage was instigated the same day.

One week later another drainage tube was placed below the original incision and into the fascia of the neck. Sulfanilamid therapy was given for a period of forty-eight hours with no apparent benefit. The temperature remained around 102 degrees during this time, with very little drainage from either incision. On March 1, roentgen therapy was started, the temperature on that day being 101.6 degrees. These temperatures are rectal readings.

The following day the temperature rose to 102.4 degrees. On March 6, the high temperature for the day was 99.4 degrees. Radiation was given on that day. The temperature dropped to normal in the morning of March 7, with slight variations during the day and a normal temperature reading in the morning. Another treatment was given on March 10. Copious drainage was noted on the dressing at this time. The temperature remained normal in the morning, rising somewhat in the afternoon. On March 22, considerable swelling appeared. The temperature rose to 101.4 degrees. On March 23, radiation was again given. The temperature on March 24, in the morning, was normal. Radiation was repeated on March 25 and 28, and April 7. Frequent x-ray films were taken during the process of treatment, and at one time a slight rarefaction was noticed about the edges of the wound, suggestive of osteomyelitis. Subsequent x-ray findings showed considerable recalcification about the fracture line.

It was noted with great interest that, following radiation therapy, the drainage was greatly increased. The patient was dismissed on April 28 with no edema and no drainage from either incision, and was able to masticate food, the teeth being in excellent occlusion.

* * *

CASE 2.—A white female, age 26, entered the hospital on June 30, 1936, with edema of the entire right side of the face, extending down into the neck. This was a cellulitis due to an unerupted lower right third molar. The temperature on being admitted was 100.4 degrees. A marked trismus was present and the patient was obviously in great pain.

The following morning incision and drainage were instigated from the cheek into the mouth. No pus was demonstrated upon drainage. Later, the same day, radiation was given. The following morning the temperature was 101 degrees, and in the late afternoon the temperature was 102.8 degrees. On July 3, another radiation treatment was given, the high temperature for that day being 102 degrees. On July 4, the temperature dropped from 102 degrees at eight o'clock in the morning to 99.8 degrees in the late afternoon. The drainage on the dressing, in the morning of July 5, was copious, the temperature being down to normal. A slight fluctuation in temperature occurred for several days, and the patient was discharged practically temperature-free on July 7.

I have been fortunate in obtaining similar results in several others. A Ludwig's angina was treated without benefit. A rich drainage of foul-smelling B. coli pus occurred for a day or two before death.

Gas Bacillus Infections.—Excellent results are reported, but I have had no personal experience.

Herpes Simplex.—The use of 150 to 160 r of unfiltered radiation, measured in air, to the lesion almost invariably stops its further development. It is, therefore, important to radiate the lesion as soon after the first symptoms as possible. In some cases the effect is better if the Gasserian ganglion on the involved side is given 75 to 100 r of filtered radiation at the same sitting.

Herpes Zoster.—Irradiation of the involved nerve roots in the acute cases will shorten the course of the disease from 50 to 75 per cent. Local radiation of the herpetic lesions adds to the effect. The most startling and spectacular effects are seen in the postherpal neuralgias. Sometimes the pain is relieved by the first irradiation, at others the pain is aggravated for a short time before the relief is felt. This increase of pain, I believe, indicates a larger dose than is needed for that particular patient. I have found that two to four irradiations given twice a week are usually all that are necessary, although a few patients required a longer series before complete disappearance of the neuralgia occurred.

COMMENT

There are other similar or related conditions in which irradiation has been found of value, but the limited scope of a section paper prevents their inclusion, and it is hoped that the discussion will broaden the field already covered.

As many of these patients must be individualized in planning treatment, it is of prime importance always to keep the following effects of radiation in mind, especially when deciding on the size of the dose and the timing of the treatment or treatments. Bacteriolysins in the blood are increased. Treatment before antigens are formed or injected reduces or prevents the formation of antibodies, but with normal doses does not affect already formed antibodies and at the same time inhibits the removal of antigens from the blood. This inhibition is supposed to occur through an inhibitory effect on the reticulo-endothelial system. Radiation interferes with the production of anaphylactic bodies and the elimination of antigens present. It restrains the formation of specific bacterial agglutinins and lysins. Irradiation of the spleen with 150 r or less increases immunity reactions. Irradiation with 300 r produces no effect, *i. e.,* on immunity reactions. In the few patients whom I have observed, I believe that I obtained a more prompt and pronounced effect when I irradiated the splenic area with 100 r total or skin dose, simultaneously with the irradiation of the affected region in acute pyogenic infections.

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DISCUSSION

ROBERT S. STONE, M.D. (University of California Hospital, San Francisco).—Doctor Ullmann has given us again a discussion of a timely subject. Radiation therapy of inflammatory conditions is well known to radiologists, but its value is appreciated too little by the general practitioners and surgeons who first see the patients. The subject has been broadly covered by the essayists, but there are two conditions that should be somewhat more emphasized.

Pneumonias, both lobar and broncho types, have been the subject of intensive study in recent years, with special attention to treatment with serums. In the enthusiasm for serum treatment the work of Dr. Eugene Powell of Temple, Texas, has passed comparatively unnoticed. He reported better results in Type I infections than have been obtained with serum. The patients reported subjective improvement in two or three hours. Powell's results challenge us to give such effective treatment to our patients or to prove that he was wrong in his interpretation of his results. He used doses of 250 to 300 roentgens over the involved areas.

Infections with the gas bacillus are not common, and most of us are seldom called upon to treat many cases. The collective experience of those who have used x-ray therapy as soon as such an infection was discovered forces us to the conclusion that the first therapeutic agent to be thought of should be x-rays. When an agent acts so promptly and efficiently, we should not withhold it merely because we do not understand how it works.

In the case of furuncles and carbuncles, I should like to emphasize that x-rays should be thought of, not as a last resort, but as the treatment of choice to be instituted as early as possible. Unfortunately, because of the years of training that the laity have had in not being treated till a "core" or "pus" has been found, patients seldom present themselves early in the course of the disease.

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Frederick H. Rodenbaugh, M. D. (490 Post Street, San Francisco).—Doctor Ullmann again reminds us that in recent years the radiologists have devoted the major portion of their time to the therapy of malignant disease and have not fully explored the use of radiation in nonmalignant disease.

The knowledge that the metabolism and function of the connective tissues and parenchymal cells are extraordinarily increased by inflammatory processes explains why physically equal doses of radiation have a more marked effect on inflammatory cells than on normal cells, provides a rational basis for all radiation therapy.

This effect is both local and systemic, and the type of therapy is, therefore, dependent on the lesion; and justify an increasing use of radiation therapy on the so-called inflammatory lesions. We should be guided in our selection of such cases by our clinical judgment, until more precise measurements are available.

Doctor Ullmann's reports are most interesting and instructive, and we should be grateful to him for calling to our attention this frequently neglected group as radiation problems.

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Orville N. Meland, M. D. (1407 South Hope Street, Los Angeles).—While radiation therapy has been used most extensively in malignant disease, its greatest use probably lies in the various inflammatory conditions, a few of which Doctor Ullmann has mentioned. Years ago radiation was used empirically, but now it is believed that its value is due to its effect on the lymphocyte, one of the most radio-sensitive of all cells. Therefore, it is easily seen that the dosage for a favorable result is very small in comparison to the one used in malignant diseases.

One wonders why radiation is used in such a variety of disorders; the answer is rather simple. All metabolic changes in the body are due to disassociation of chemical substances into positive and negative ions, and their free interchange through cell membranes. The effect of radiation in the tissues is due to the ionization it sets up in the areas treated, thus speeding up chemical changes which may be so violent that the cell dies, liberating immune bodies.

The use of radiation for the various inflammations does not mean that we should discard the old and tried methods, such as hot compresses, surgery, and specific drugs, but the profession should know that it represents another supplementary aid. This is particularly true in such entities as gas infections, unresolved pneumonias, and actinomycosis.

PRURITUS ANI*

By Charles R. Caskey, M.D.
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In the majority of cases of pruritus ani, the cause of the itching is, in my opinion, associated with some local pathology. I cannot subscribe to the theory of some clinicians that this ailment is a definite disease entity. All cases should not be treated alike by injections or by vaccines, as has been advocated by some, for 100 per cent results cannot be secured by any one method of treatment. Success must depend upon our ability to make a correct etiological diagnosis and properly apply the appropriate treatment. Of this greater percentage of cases due to local conditions, some arise from causes of a dermatological nature. It is this group that I wish to discuss in this short essay.

CAUSES OF PRURITUS ANI

In order to visualize and segregate dermatological causes of pruritus ani, I have compiled a complete list of causes ascribed to this distressing symptom.

Anorectal conditions	Hemorrhoids	Infection of anal ducts
	Fissures	Chronic proctitis
	Fistulae	Parasites
	Polypi	
Genito-urinary diseases	Nephritis	Endometritis
	Cystitis	Prostitis
	Cervicitis	Posterior urethritis
	Vaginitis	Vesiculitis
Systemic conditions	Diabetes	Cholecystitis
	Renal disease	Hepatic cirrhosis
	Constipation	Allergy
	Menopause	Alcoholism
	Senility	Use of tobacco
	Diatetic errors	Psychoneurosis
Skin diseases	Lichen planus	Bacterial infections
	Psoriasis	Fungus infections
	Circumscribed neurodermatitis	
Idiopathic pruritus ani		

ANALYTICAL CRITERIA

I shall now briefly outline the criteria by which to segregate those cases in the field of a dermatologist. This can be done to a certain extent by a process of elimination, and by evaluation of direct and indirect symptoms of a particular case after a careful history and examination. Proctological, urological, gynecological, or internal factors should be considered in a complete examination and careful consideration of their value noted. In many cases it is an advantage to have the opinion of one or more of the specialists in the fields just mentioned. It is especially important to know whether or not there is rectal pathology present. This should be ascertained before beginning treatment, even though there is evidence of skin involvement. A more or less severe dermatitis may be present, but due wholly to trauma, secondary infection or to irritating treatment. A careful history and examination will help us to evaluate these factors. Our examination should include not only the anal area of the skin, but also other parts of the integument for signs of lichen planus, psoriasis, neurodermatitis, or other conditions.

Lichen Planus.—Lichen planus, occurring in the anal area, is distinguished by violaceous patches made up of smaller individual polyangular flat-topped lesions. Unless severely excoriated and irritated by strong applications, the condition is not exudative. It is not likely to occur about the anus without showing typical patches elsewhere on the skin or mucous membranes. The treatment is that usually given lichen planus, namely, arsenic by mouth or parenterally, and roentgen therapy locally.

Psoriasis.—Psoriasis does not often occur in the anal area. When it does, it is likely to show as a white sodden area extending up from the anal area to the upper part of the intergluteal region. Not infrequently the condition takes on a "beefy" appearance. It seldom occurs in this region without at the same time appearing in well-defined patches in other intertrigenous areas, and is rarely pruritic. The most effective treatment is x-ray.

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* Read before the Dermatology and Syphilology Section of the California Medical Association at the sixty-seventh annual session, Pasadena, May 9–12, 1938.

Circumscribed Neurodermatitis.—Circumscribed neurodermatitis may appear in the anal region. If it does, it shows as a localized, lichenfied, infiltrated patch of a dry rather than moist character. The patch does not usually invade the anus, but lies without the folds of the anal circle. For this condition x-ray is again the local remedy of choice.

Bacterial Infections.—Bacterial infections may attack the anal and perianal area. Pyogenic infection is recognized by a purulent discharge. Streptococcic infection in this location is rarely the cause of troublesome pruritus. These conditions can be treated with antiseptic solutions chosen to combat the particular organism proved to be the etiological agent.

Fungus Infections.—It is my opinion that, of the dermatological causes of pruritus ani, most of them are due to fungus infections. This opinion in most instances is based on clinical findings. Since the anal area is so subject to contamination that examination of the scrapings or of cultures are likely to give us false impressions, it seems hardly worth while to carry out routinely these diagnostic procedures. This is unfortunate in some respects, but in most cases treatment has to be carried out symptomatically. If there is a severe dermatitis, this must be dealt with by appropriate, soothing remedies before one can use medication directed against a specific organism. For clinical confirmation of a diagnosis of mycotic pruritus ani one should look for a sodden, epidermal circle of varying radius extending outward from the anus. This sodden epidermis not infrequently extends upward between the gluteal folds. One should search also for evidence of tinea cruris, which may be present in the groin as small or large, well-defined red scaling areas. The finding of sodden interdigital epidermis is confirmatory evidence of a mycotic etiology. It shows that the patient is susceptible to fungus infections, and that he has a focus on the body and may have transferred the disease to another location. I regard, also, patches of eczema on hands or other parts of the body as highly significant, and on these findings I classify the case as one due to fungus infection. To substantiate my impression that some of my cases are due to fungi, I have observed several cases of pruritus ani which developed typical phytid vesicles in the palms, and many cases have had lesions of fungi elsewhere on the body.

PATHOLOGY

The study of the pathology of pruritus ani has not been of much assistance in arriving at an etiological diagnosis in this disease. The histopathology is that of an acute or chronic process, with only the cellular changes found in any acute or chronic skin disease.

TREATMENT

The treatment of pruritus ani must, in many instances and particularly in a new case, be directed to giving symptomatic relief. If the skin is very raw and excoriated it is advisable to discontinue all previous medication, even so-called anesthetic ointments. A severe dermatitis is not infrequently dermatitis medicamentosa. To a dermatitis medicamentosa is often added another insult—actinic dermatitis. After using ultra-violet light for many years, I feel that it has no place in the treatment of pruritus ani. It is contra-indicated in all acutely inflamed dermatoses.

In medicine it is just as important to know what should not be done as it is to know what should be done. Hence, if the case is acutely inflamed I rely on a soothing application, and my choice is the well-known Burow's solution diluted with cold water. It is doubtful if aluminum acetate ever produces irritation. A second choice as an astringent and antipruritic is potassium permanganate in 1-3000 dilution. It may be used stronger or weaker, according to indications. Strong remedies should be used with caution for a few days. At this acute stage treatment should be directed toward calming the extremely nervous patient. Morphin or barbiturates I regard as contra-indicated. I feel that I have had some sedation from moderate doses of bromids. In one case hypodermic injections of codein proved very satisfactory in tiding a nervous, exhausted patient over the crisis. This particular patient could only tolerate Burow's solution locally, and after several weeks of its persistent use was rewarded by complete relief. His case began as pruritus ani, but extended to groins, genitals, and finally by sensitization to feet, hands, and face.

During the acute stage, treatment with x-ray must be used with caution lest we make our patient more uncomfortable. My preference is to withhold its use until an acutely irritated skin has been brought under control by the soothing applications first mentioned. To accomplish this it may be necessary to hospitalize the patient where medication, diet and hygiene can be controlled, for these cases sometimes drift into a state in which they will not control themselves. Patients should not be labeled neurotic or psychotic just because they are beside themselves from intolerable itching and loss of sleep. When acute inflammation has somewhat subsided, one may cautiously begin the use of mild, soothing ointments.

As a local anesthetic and antipruritic, phenol one per cent in petrolatum may be sufficient. In some cases I have found the addition of menthol one-half per cent to this ointment soothing. Equal parts of chloral hydrate, menthol and camphor, rubbed down to a fluid, may be applied in small amounts for the relief of itching.

The physician should emphasize to the patient that instant and complete relief is not to be expected except from injection of local anesthetics. Even these have their hazards and disappointments. Remedies should not be too strong or complex, lest one irritate with chemicals an alreadly hypersensitive tissue.

At this point the cautious use of x-ray is beneficial in both mycotic and nonmycotic types of pruritus ani. It has unquestionable antipruritic effect, and at the same time checks the secretions in an area predisposed to the growth of organisms which thrive in warmth and moisture. The dosage and frequency of its application must be left to the judgment of one familiar with its use and its joint effect with the other remedies used. Here discretion is the better part of therapy. If by this time one has reached conclusions as to etiology, therapy should be directed toward removing the cause of the pruritus.

If the case is one of mycotic nature, I usually prescribe an ointment consisting of 1 to 3 per cent salicylic acid and 2 to 5 per cent sulphur, or iodin, oil of cinnamon, and thymol, each one-half per cent in petrolatum. Caution has to be exercised as to strength permissible, depending upon rawness of anal epidermis. The effect may be materially enhanced if the patient is required to wear a soft cloth pad to hold the ointment in apposition to the tissues. The dressing prevents also soiling of the clothes and lessens the temptation to scratch.

Fissures and raw excoriated points can be made much less painful if painted every two or three days with 5 per cent silver nitrate solution. If the skin is not too irritated I paint the area with a solution composed of phenol 0.3, tincture of iodin 5, camphor water q. s. ad. 30. Before applying this the ointment should be removed with a mild soap and soft washcloth and the skin dried. After the paint dries, while the buttocks are held apart, borated talcum powder should be dusted on the area. This is preferable for day treatment, as it is dry and does not soil the clothes. Ointments are better for night treatment. The paint may sting quite sharply when applied, but that passes off in a few minutes. It may be applied twice a day and the ointment discontinued if the patient gets more relief from it. In some cases a medicated paste may give most relief, such as 1-2-3 paste. Always watch for possible irritation from your medication. One must distinguish between irritation and the spread of the disease. Remember, nature does the healing and do not get in her way.

General hygienic measures should be instituted at the patient's first visit and should be directed to general health, sleep, rest, nutrition, bowel function, and local cleanliness. The anal area should be cleansed with a mild soap and water after each bowel movement. Remember, pruritus ani more frequently occurs in the nervous, overworked, anemic individual. Investigate all body functions and correct as indicated. It may be advisable to proscribe liquor, coffee, and tobacco.

SUMMARY

1. The numerous possible causes of pruritus ani have been enumerated and it has been emphasized it is the opinion of the writer that most cases are due to some dermatological condition, and that a large percentage of these are caused by fungus infections.

2. A method of treatment is outlined with emphasis toward giving symptomatic relief, while at the same time attacking the causative factor. The importance of nonirritating and soothing remedies in acute cases is stressed. Overmedication or too frequent use of physical agents are dangers to be avoided. The proper use of roentgen ray in the treatment of pruritus ani is of great therapeutic value.

3. Local and general hygienic measures are mentioned last, but it is important that they receive due attention.

1930 Wilshire Boulevard.

RENAL FUNCTION IN THE AGED*

By L. Dale Huffman, M.D.
Hollywood

THE development of tests of renal function, based on the conception of glomerular filtration and tubular resorption, has provided the clinician with quantitative methods for the measurement of the phases of the secretion of the urine. These methods are being successfully applied in evaluating renal function. I wish to report the findings resulting from the application of some of these tests in the physical examination of the very old.

PATIENT GROUPS UNDER OBSERVATION

Four groups of persons, seventy years of age and older, were examined; all were ambulatory. In one group were fourteen men and twenty-two women school teachers, all actively engaged in their profession. The nonprotein nitrogen and uric acid of the blood, the urinalyses and blood pressure readings are tabulated (Table 1). In a second group were five school teachers and five well persons more than eighty years of age, who volunteered to have the tests. The phenolsulphonephthalein tests, urea-clearance tests, and Addis's sediment counts are shown (Table 2). In a third group are patients seventy-five years of age or older. Data from the blood pressure readings, the nonprotein nitrogen tests, the phenolsulphonephthalein tests, and the urinalyses are shown with the diagnosis of the major pathologic condition (Table 3). The fourth group were men who complained of dysuria, and in whom blood pressure readings, phenolsulphonephthalein tests, urea-clearance tests, and Addis's sediment counts were done (Table 4). Specimens in this group were obtained by catheterization. The methods utilized in performing the tests are outlined by Belt in Volume II of "Modern Urology" by Cabot.

RESULTS OBSERVED

The blood pressure in the group of school teachers was elevated in four instances, all women. Albuminuria and casts were present in fourteen cases out of thirty-six, and an abnormal number of leukocytes was noted in the urine of four men. The nonprotein nitrogen and uric acid of the blood were not increased above normal. The specific gravity

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* Read before the General Medicine Section of the California Medical Association at the sixty-seventh annual session, Pasadena, May 9-12, 1938.

Table 1.—*Tests of Renal Function in School Teachers*

				Urinalysis—Twenty-four Hour Specimen				Blood Chemistry	
No.	Age	Sex	Blood Pressure	Specific Gravity	Albumen	Casts	Leukocytes	N. P. N.	Uric Acid
1	72	M	150/100	1.016	Tr.	+	25–35	33.4	4.1
2	73	M	150/90	1.022	0	0	Occ.	27.0	3.2
3	71	F	150/80	1.015	0	0	Rare	39.8	4.2
4	70	F	170/80	1.016	Tr.	+	Rare	27.0	4.7
5	70	F	140/90	1.010	0	0	3–4	22.0	3.0
6	72	M	154/86	1.018	0	0	Occ.	29.4	2.9
7	71	M	160/90	1.024	0	0	Rare	31.0	4.0
8	70	F	155/84	1.015	0	0	Rare	26.0	3.3
9	70	F	200/90	1.010	Ft. Tr.	0	Rare	27.8	3.3
10	74	M	130/70	1.020	Ft. Tr.	+	++	24.3	3.1
11	71	F	180/100	1.008	Ft. Tr.	0	1–2	23.8	2.3
12	71	F	150/100	1.010	0	0	Occ.	36.0	3.1
13	71	M	140/80	1.025	Tr.	0	8–12	36.4	3.2
14	73	F	140/84	1.004	+	+	1	27.3	3.1
15	70	F	120/70	1.004	Tr.	0	Occ.	38.4	3.9
16	72	F	140/90	1.010	Ft. Tr.	+	Occ.	34.1	3.0
17	70	F	140/75	1.014	0	0	Occ.	30.3	3.7
18	70	F	160/90	1.020	Tr.	0	1–2	23.0	3.3
19	71	M	130/80	1.028	0	0	Rare	23.4	3.1
20	75	M	144/86	1.022	0	0	Rare	34.9	4.3
21	70	M	140/80	1.020	0	0	1–2	23.9	3.4
22	70	F	180/84	1.010	0	0	Rare	32.0	4.0
23	71	F	140/95	1.015	0	0	Occ.	29.4	4.0
24	70	F	160/90	1.018	0	0	0	27.4	2.8
25	70	F	120/80	1.010	0	0	1	32.0	4.8
26	71	F	140/80	1.016	0	0	304	38.8	4.0
27	74	F	140/80	1.012	Tr.	+	Occ.	39.0	3.0
28	71	M	124/78	1.012	0	0	Occ.	33.7	4.1
29	71	M	124/80	1.030	0	0	Occ.	32.4	2.4
30	75	F	150/80	1.010	Tr.	+	Occ.	40.4	3.8
31	73	F	160/95	1.020	0	+	2–3	38.0	4.0
32	71	F	160/90	1.015	Tr.	0	1–2	38.4	3.1
33	70	F	165/85	1.014	Ft. Tr.	0	Occ.	29.6	3.0
34	79	M	144/90	1.008	Tr.	+	Loaded	27.8	3.2
35	74	M	148/88	1.008	0	0	Rare	34.7	4.0
36	70	F	180/110	1.008	0	0	Occ.	29.7	3.4

of the urine did not show significant alteration in any case.

A comparison of tests of renal function in the "normal" old persons is found in Table 2. Values for the two-hour phenolsulphonephthalein test and the urea-clearance test are normal. There were reduced amounts of phenolsulphonephthalein returned in the first fifteen-minute specimens. Large numbers of leukocytes were found in all the sediment counts in this group, and in four of the men extremely large numbers were found. Casts and traces of albumin were frequently present. The specific gravity of the urines was not unusual.

The results of the tests of renal function in fifteen aged patients are shown in Table 3. Cases 3 and 13 were women. The systolic blood pressure was 170 or more in four. The nonprotein nitrogen of the blood was 40 milligrams per 100 cubic centimeters or more in eight instances. The per cent of phenolsulphonephthalein returned in two hours was 45 or lower in five, while the per cent returned in the first fifteen minutes was frequently below 30. The urea-clearance values were below normal in four instances and in the questionable range in four others. The urea-clearance of 206 per cent in the 78-year-old man is of interest. He was markedly aphasic and somewhat deaf. It was not determined if he had had his morning coffee. Albuminuria and casts were frequently present in the urine of these aged patients.

Table 2.—*Tests of Renal Function in "Normal" Old Persons*

Age	Sex	PSP		Urea Clearance	Addis' Sediment Count				
		Fifteen Minute	2-Hour Total		Erythrocytes	Leukocytes	Casts	Specific Gravity	Albumen
70	F	30	69	78	0	2,000,000	478,000	1.024	h. tr.
72	M	35	63	73	0	14,000,000	3,000	1.022	0
74	M	20	79	81	0	2,000.000	59,000	1.020	tr.
71	F	40	90	108	0	2,000,000	6,000	1.023	tr.
77	M	30	67	112	6,000	60,00,000	0	1.025	0
80	M	27	75	84	12,000	20,000,000	5,000	1.033	0
82	F	18	72	70	0	1,000,000	16,000	1.020	h. tr.
84	F	28	83	64			6,000	1.022	h. tr.
85	M	30	80	89	0			1.026	0
88	M	20	65	70	0	120,000,000	4,000	1.020	tr.

The frequent occurrence of large numbers of leukocytes in the urine of the aged men is noted, while erythrocytes occurred rarely.

Increased blood-pressure readings and reduced phenolsulphonephthalein return in fifteen minutes are noted in each of three of the elderly men who sought relief for difficult and painful urination (Table 4). The return of 60 per cent of phenolsulphonephthalein in one case, in which a urea-clearance value of 36 per cent of normal was found, is unusual. The urine findings suggest renal impairment. The urea clearance values were low in five. Erythrocytes and leukocytes were present in greatly increased numbers in all. Casts were found in five.

COMMENT

Serious degrees of impairment of renal function is not a necessary accompaniment of old age. In these groups of cases true nephritis is rare, and while slight degrees of nitrogen retention are not unusual, the classic picture of uremia is infrequent. The large number of leukocytes so frequently found in the urine of the elderly male is significant. My data indicate the frequent association of kidney impairment and prostatic hypertrophy. Twelve of the fourteen male school teachers had some palpable enlargement of the prostate. The 79-year-old man had had a prostatectomy. The gradations from a symptomless enlargement to complete obstruction may be almost imperceptible. Where evidence of renal impairment exists in the male it is obligatory to rule out obstructive uropathy before a diagnosis of true nephritis is made.

The presence of albumin and casts and fixation of specific gravity of the urine in either sex clearly indicates that other functional tests should be employed before any conclusions are drawn regarding the renal status. There is usually adequate function if the excretion of phenolsulphonephthalein approaches 40 per cent in the first fifteen-minute specimen, and 60 per cent in the two-hour specimen. Likewise, when the value of the urea-clearance test in per cent of normal is 70 or more, good renal function is usually present. When values of urea-clearance are 50 per cent of normal, some impairment is present and values from 50 to 70 per cent should be considered doubtful, and other tests of renal function employed. When clearance studies

Table 4.—*Tests of Renal Function in Elderly Men With Complaint of Dysuria*

Age	Blood Pressure	PSP		Urea Clearance Per Cent of Normal	Addis' Sediment Count				
		Fifteen Minute	Two-Hour Total		Erythrocytes	Leukocytes	Casts	Specific Gravity	Albumen
70	200/130	20	70	50	29 000,000	67,000,000	9,000	1.022	0
70	144/80	30	79	97	1,200,000	106,000.000	0	1.018	0
71	138/74	4	58	48	1,000,000	10,000,000	0	1.017	Tr.
71	160/80	25	69	72	12,000,000	80,000.000	0	1.020	0
72	130/70	20	60	36	147,000,000	2,800,000	48,000	1.024	0
73	140/80	35	80	74	300.000	2,100,000	0	1.025	0
74	135/90	28	71	56	93,000,000	68,000,000	5,000	1.020	+
74	135/90	Repeat one week later			87,000,000	60,000,000	10,000	1.015	+
77	140/90	30	67	112	3.000,000	3,000,000	0	1.020	0
80	180/90		45	61			+	1.024	Tr.
82	200/100	0	Tr.	20				1.010	++

show values less than 25 per cent, a dangerously low level has been reached in the aged person. It is implied throughout that the sources of error in technique have been dealt with, particularly inaccuracy in timing specimens and in incomplete emptying of the bladder.

The use of the Addis sediment count is not general. It is time-consuming and requires strict co-operation of the patient. When these conditions are met the author believes the information obtained amply repays the time and effort spent. It may become the most useful single procedure.

The level of the nonprotein nitrogen of the blood may be of significance in showing kidney impairment. Elevated values are regularly found when the urea clearance is 20 per cent of normal, and half the time when the urea clearance is from 20 to 40 per cent of normal.

It is difficult to analyze the factor of blood pressure as related to renal function in the aged. Some elevation of blood pressure normally occurs up to the eighth decade. It is probable that vascular narrowing in the renal bed, incident to advancing years, necessitates a physiological increase in the general blood pressure to facilitate the work of the kidney.

CONCLUSIONS

In the evaluation of renal function no single test is to be preferred above all others. It is frequently necessary to investigate all the possible angles, particularly so where early insufficiency may exist. The urea-clearance test is a valuable index of renal function, and, where exactitude in collecting all the urine voided in a specified time has been done, impairment of renal function is demonstrated before the urea, uric acid or creatinin of the blood is increased. Accuracy in collecting specimens is interfered with where urinary obstruction or incontinence is present. This may be partially overcome by catheterization. The tests of specific gravity indicate the ability of the kidney to concentrate and dilute. It may be disadvantageous in the aged to impose extreme water restriction or to overburden a failing myocardium with excessive amounts of fluid. It is probable that the aged organism requires less fluid for its reduced metabolism than younger age groups.

The limitations of the phenolsulphonephthalein test are the same as those of the urea-clearance test, while

TABLE 3.—*Tests of Renal Function in Patients Seventy-five Years of Age or More*

				PSP			Urine Findings					
No.	Age	Blood Pressure	N. P. N.	Fifteen Minute	Two-Hour Total	Urea Clear-ance	Specific Gravity	Albumen	Casts	White Blood Corpuscles	Red Blood Corpuscles	Diagnosis
1	75	140/80	40	18	79	81	1.022	0	3,000	14,000,000	0	Diverticulitis
2	76	145/90	31	40	79	83	1.024	Tr.	0	2–3	0	Hyperprostate
3	77	140/90	29	25	67	112	1.020	0	0	3	0	Bronchitis
4	77	140/70	47	0	62	65	1.015	Tr.	0	++	0	Hyperprostate
5	78	160/90	34		80	206	1.012	0	0	1–2	0	C. N. S. Arteriosclerosis
6	79	140/90	34	20	80	89	1.020	0	Occ.	Occ.	0	Arteriosclerosis
7	80	165/80	28		58	70	1.016	++	+	Loaded	0	Ca. of prostate
8	80	170/110	24	10	45	61	1.018	+	0	+	+	Hyperprostate
9	82	100/34	44	5	38	30	1.012	++	+	++	+	Ca. of prostate
10	82	160/80	60	35	72	55	1.019	++	0	Loaded	+	Hyperprostate
11	83	200/100	80	0	10	26	1.010	+	++	+++	0	Cardiovascular
12	85	140/90	30	25	75	73	1.022	0	0	0	0	No. disease
13	85	170/90	40	35	80	60	1.020	+	+	+	0	Ca. of stomach
14	86	200/100	40	0	5	20	1.012	+	+	+++	0	Cardiovascular
15	89	160/100	50	0	38	50	1.010	++	+	+++	0	Myocardial

its range is more restricted. Where the urea-clearance test may indicate 20 per cent of normal function or less, the phenolsulphonephthalein return may be zero. The ease with which the phenolsulphonephthalein test can be carried out, however, far outweighs the disadvantages cited. Further, when the intravenous method is used and collections are made at fifteen-minute intervals, the resultant data give significant indications of small changes in renal function.

SUMMARY

The combined use of the phenolsulphonephthalein test and the urea-clearance test, in conjunction with the qualitative tests and microscopic examination of the sediment, and a study of variations in specific gravity, furnishes reliable data by which renal function may be studied in aged patients. Such a study, carried out in sixty-seven aged patients, reveals the fact that serious degrees of impairment of renal function is not a necessary accompaniment of old age.

Therefore, if positive findings of diminished function in an elderly individual are discovered, one must predicate the existence of a disease process in the elderly just as in other age groups.

6305 Yucca Street.

MEDICAL-ECONOMIC PROBLEMS*

By Harry W. Sawyer, M.D.
Fallon, Nevada

With the ever changing political situation this is quite an appropriate time to call your attention to conditions with which we are all familiar, but unfortunately feel that we should "let George do it." I think the time has arrived when every medical association and every member of every medical association should realize the fact that if the standards and the ethics of the profession are to be maintained in the slightest degree, that the responsibility for that maintenance devolves upon the individual members of the medical profession in active participation in the so-called socialized medical programs that have been promulgated at the present time.

The purpose of these remarks today is to stimulate interest in our own welfare. At the present time our activities are outlined and our future is being shaped by the politicians of the country and it is up to us to decide whether or not we are willing to sit back and let that condition continue to exist until such time that any protest that we may see fit to make will be of no avail.

FEDERAL PUBLIC HEALTH PROGRAM

You are all familiar with the $850,000,000 program that is being advocated in Washington and undoubtedly this will come up at the next session of Congress and undoubtedly this will pass under the title of "Social Medicine" which I think is a subterfuge to regiment the physicians of the country. It is a good catch phrase to catch the public mind. It is something we feel is for nothing. Eight hundred fifty million dollars is to be expended upon this program and to date no provision has been made for the dispensing of that enormous amount of money by any medical organization. It is to be in the hands of the laymen. The medical man is to be that of a hired individual who is to be directed in his efforts and to be censured and criticized for the ill results that may result from this procedure, the politicians taking unto themselves any credit that may result from this activity. Eight hundred fifty million dollars is to be expended presumably for public health and to date not one single physician has a word in the set-up as to how this money shall be spent.

MEDICAL CARE OF THE INDIGENT SICK

The medical care of indigents is a community responsibility. It is not the responsibility of the individual physician; it is not the responsibility of any local hospital, but is a community responsibility. The program as outlined and put in effect today depends upon the coöperation of the individual private practitioner throughout the country. These programs are promulgated and developed and individuals come into the field to direct the application of this program. They have approached the local practicing physician and impressed upon him the necessity of his coöperation if this program is to be a success. In the course of the conversation there always develops the cost of this care that he is to give the patient. They start off with a reduction in fees and eventually wind up by giving this service gratuitously. The attitude of the medical profession toward the sick and suffering has always been to relieve that irrespective of any benefit that he personally may derive. When the conditions in the country permitted the physician to select those individuals to whom he might extend his service, that was all well and good, but today everybody that needs medical attention through these various programs that have been developed, is under the impression that he should receive medical attention free of charge. That thought is encouraged and developed by the various programs underway.

The result is that the physician's good nature is imposed upon and in order to give this program a start and by endeavoring to relieve the suffering in his community, he agrees to do this gratuitously. He then is asked to make reports which he does, many times at his inconvenience. These reports are forwarded to headquarters at the end of the year, and the various individuals who have charge of the program make a very elaborate and detailed report, the inference being that this has been the result of their personal efforts, but primarily this report is taken before the legislators and invariably an increase in appropriations is asked as the result of the remarkable showing they have made in the previous year or years, while the truth of the matter is that this showing has been the result of the coöperation of the private practitioner for which he gets no credit. Conditions economically and socially are rapidly undergoing changes in the country. The same thing applies to the practice of medicine and the attitude of the physician toward the public and the individual patients.

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* President's address, thirty-fifth annual meeting of the Nevada State Medical Association, held at Reno, Nevada, September 23-24, 1938. For minutes, see page 56.

Thomas Parran has made this statement: "It is not unlikely that public health may be the next great social issue in the country." It is the next great social issue and at the present time is being actively developed; I am sorry to say, not for the benefit of the sick and suffering of the country, but in an endeavor to create another political unit that can be driven to the polls on election day and told how they shall vote, being held before them always the dollars and cents of an appropriation and the result that will be given their states because of their voting right and the threat of withholding the appropriation if they don't vote right.

An important conference was held in Washington in July, 1938. A very significant phase of that was the presence of Miss Josephine Roche as the secretary and those of you who attended the last American Medical Association convention at San Francisco recall her nonappearance to address the House of Delegates.

WASHINGTON ACTIVITIES

Now in regard to this health conference and the creation of a Bureau of Health, every organization, every physician in the country should insist that the secretary of that bureau be a physician. Apparently the intent and purpose at this time is not to do that. Again the practice of medicine and the care of public health are to be taken over by the laity, and the physicians of the country are to act in a subordinate position and are not to be consulted as to the program, and are not to have any influence in the direction and spending of this enormous amount of money, but the laity itself with the end result that some "boob's" political position is enhanced.

In regard to this controversy of public health we are not without supporters. The laity fortunately have sensed what is in the air and in certain places and in certain society they are informed. At this time I want to read a little editorial that occurred in a mining journal, the *Mining and Contracting Review* printed in Salt Lake City, now in its fortieth year and this is an expression of opinion by the editor of this paper who cannot be accused of having any particular interest in any financial return that might result from his attitude, so I think this editorial is well worth reading and I am going to take a moment of your time. It is entitled, "The People Know Better."

"We believe the latest Department of Justice inquisition, started by some crackpot will prove to be a complete fizzle. Following New Deal tactics of attempting to create mass hate toward all who accomplish, manage, and provide employment, the Department of Justice is now conducting an assize against the American Medical Association—the leading association of physicians and surgeons.

"The class to which this inquisition is supposed to appeal knows better and all who have real acquaintance with the medical profession know better. Every worker, best of all miners and construction workers, know better.

"The unfortunate and penniless know better. We know doctors whose annual charge off to profit and loss for 'charity' work exceeds the annual pay of officials in the Department of Justice, including the income of the pitiful Cummings himself.

"All this inquisition has to do with New Deal desire to control everything, even to the death rattle of humanity. From the current panorama of incompetents engaged in conducting the Government of the United States, one can picture the brand of treatment the sick and injured would receive under political control stripped of the pride and scientific fire possessed by a vast majority of the medical profession. The people know better."

Editorials of that nature in this type of magazine are very encouraging and I feel it is an indication that if the members of the medical profession will take the lead and make an endeavor to control the care of public health, then innumerable other organizations and magazines of this type will come to our support.

Now that is as far as we can go with the federal intervention in the practice of medicine. One could probably discuss it here for quite some time, but the thing appealing to you gentlemen is that occurring in the State of Nevada right in front of your nose.

NEVADA EXPENDITURES

The report of the State Controller appearing in the Reno *Evening Gazette* under date of September 8, and the heading of "Disbursements for the Fiscal Year Ending June 30, 1938," carries this item: Health and Sanitation, $539,625.23. That is better than $5 for every man, woman and child in the State of Nevada that has been disbursed for the benefit of public health. The Nevada State Medical Association has not had one word to say as to how this money has been spent and who spent it. That is one thing right under our nose and we are permitting the laity to impose upon us gratuitous service, and they get in and take whatever credit of accomplishment may be evident.

The endeavor of the national administration has been to discredit the practicing physicians; their motives, their charges and their interest in public health. I don't think anybody will question these. That is the insidious way in which the present administration and the politicians are attempting to secure control of every activity in the country.

SOME NEVADA PUBLIC HEALTH PROBLEMS

In the State here there are several little things that have occurred and the end result of each and every one of them has been to discredit the medical profession, and in the developing of an antagonistic attitude toward the practice of medicine. In these little instances that I am about to cite to you, there is absolutely nothing personal, they are to be considered as conditions pure and simple that exist and the end result of these conditions arising in Nevada, should be given serious and careful consideration by the members of this association.

First is the controversy between the administration and the Secretary of the State Board of Health. Over a period of years there has been a rather sad exhibition of the lack of coöperation on the part of the political administration with the health administration in this State. Now, then, prior to this appointment we had a very efficient, competent and well liked Secretary of the State Board of Health. For reasons best known to the administration they saw fit to make a change and they made this appointment. After the appointment was made some controversy arose and in order to exhibit dislike for the individual, the health program of the State was retarded and interfered with through lack of coöperation on the part of the administration with the State Board of Health; that is, the advancing of funds and the proper attitude toward health conditions and supervision of the health of the people of the State. The result of this controversy has been to discredit the medical profession in the minds of the public. I don't think we can get away from that.

Until quite recently there has been no permanent appointment made of the chairman of the Nevada Industrial Commission. For nearly four years now this chairman has a day to day job and we all know how potent a factor the Nevada Industrial Commission is in relation to the health of the workers of the State.

The State Director of Venereal Disease Control Board and the Washoe General Hospital controversy has done anything but reflect credit upon us as practitioners and our association. One example of the control of disease by the laity was the recommendation that was made to the director that these individuals be taken out of the hospital and given a floater; the director contending that these individuals at that time were in the communicable stage, while the viewpoint of the politician was to get them out of the hospital and turn them loose upon the public in some other community and in due course of time create a financial burden along with misery to go down through the years. This is hard to comprehend but that was the attitude they took and that is an example of the way the politicians will handle the situation.

A few years ago we had this spectacle at a political banquet. The staff of a large state institution was gathered at this banquet and they set upon the table a placard proclaiming to the gathered delegates, or to the gathered politicians, that this organization was 100 per cent for a certain political party. Now, then, following that, at the session of the legislature there came a recommendation from the administration that buildings be created at this institution to cost approximately $200,000, not, mind you, for the benefit of the inmates, but for the benefit of the attendants. Is there any relationship between this proclamation of 100 per cent support for a political party and then two years hence the recommendation of the construction of $200,000 worth of buildings for those same attendants, when you take into consideration a population of 356 inmates and that at that time the report of the head of the institution showed there had been $350 spent for medicines and drugs. Maybe they are related. Maybe they come together in the control of the practice of medicine.

The results of this program at the present time to the present day have been dissatisfaction with private medical care instilled in the minds of the public; that charges by private practice are excessive; the furnishing of medical services to people well able to pay for nothing or at a greatly reduced charge; lack of appreciation for adequate and competent medical services; and the creation of resentment in the minds of the public toward the profession. Now in one day or one month or one year it isn't expected that this association can become active politically and correct or prevent the development of this undesirable condition, but we can at least start and we can outline roughly a program for the activity of this organization for this following year and as we get into it and develop it, we will have to develop a big program.

Now this probably will sound revolutionary but the fact remains that the status of the physician has materially changed. We are not in a position today to take onions or chickens in payment for our services. We must have the coin as that is demanded of us in order to pay our bills. Now, then, if the politicians are in control or attempting to assume control of the public health, it behooves us to assume an active participation in politics and to make our influence felt. A politician only understands one language and that is the language of votes; and when you can show him that an organization is in a position to materially influence the votes, you are going to get consideration in proportion to the number of votes that you can deliver on election day. Unfortunately that is not a nice procedure. It doesn't reflect credit upon anybody but at the present time that is the way the game is being conducted and until such time as we can change that, we must play the cards the way they are dealt to us and I think that this organization and every individual physician should take an active part in politics. We should have an active and aggressive legislative committee—a committee which will promulgate legislation that is to our benefit and the benefit of the public—a committee who will have their eyes open at all times and attempt to block legislation that is detrimental to the public health and to the practice of medicine. This committee should have the united support of the profession, with the insistence that this organization be consulted and our wishes given every consideration when appointments of a medical nature are to be made by the administration.

In other words, I feel that in the appointment of any man to a position that has to do with the public health program or in charge of our institutions, that the endorsement of this association should be secured; that he should be appointed for his standing in the community; his standing among physicians of the state and his qualifications to handle the position, not to pay some political debt, and I feel that this organization should make that fact evident to the politicians. We must prepare a legislative program that will safeguard the health of the public and enhance the standing of the profession in the public esteem and regard. Now, of course, that is a life program, but it is a start, and as we accomplish one or more of these objectives, we are going to extend ourselves and in due course of time we are going to be the directing factors in regard to the care of the public and the care of the public health rather than the politicians and that's the battle today, gentlemen. They are taking the control and the care of the public health and the private patients, if you please, out of the hands of the medical profession and turning it over to the politicians. That is the condition that confronts us, and it behooves us to become active and prevent the further development of this program.

TUBERCULOSIS IN SAN QUENTIN

By Leo L. Stanley, M.D.
San Quentin

II*

Discussion *by Robert A. Peers, M.D., Colfax; Carl R. Howson, M.D., Los Angeles; F. M. Pottenger, M.D., Monrovia.*

DISCUSSION

Robert A. Peers, M.D. (Colfax School for Tuberculous, Colfax).—There are, to me, among other things, two most interesting features in Doctor Stanley's report. The one is historical; the other is the practical method of attack on tuberculosis, instituted when, in 1913, he became resident physician at San Quentin.

First, the historical aspect: As one reads through the report, he is struck by the manner in which it portrays so clearly the changing viewpoint on tuberculosis from 1851 and through the decades which follow. One can make a few comments on these changes.

San Quentin was established in 1851, thirty-one years before the announcement by Koch of the discovery of the tubercle bacillus, and more than forty years before the discovery of the roentgen ray.

Thus it is not strange to note the references to the crowding together, in confined areas, of the sick and the well without respect to contagion; likewise, also, the suggestion in one report that tuberculosis falls in the class of hereditary disease. Nor is it strange that pleurisy was considered a separate disease entity and that deaths were recorded as due to this symptom.

The report of 1885 makes no reference to the discovery of the tubercle bacillus, which is not surprising to those who remember how long a time elapsed before Koch's findings were universally accepted.

The report of 1890 coincides with the pandemic of influenza in 1889-1890, and the recognition of the relation of influenza to the reactivation of tuberculosis is recorded. The quotation from this year affords the first evidence in all these reports of the recognition of the infectiousness of tuberculosis. Likewise, in this period, we note an ever-increasing number of consumptives among those sent to penal institutions, which probably reflects a growing awakening in the ranks of the medical profession, with an increase in diagnostic acumen.

Just one other note on the historical aspect of this subject: In the preceding paragraph is noted the recognition of the infectiousness of tuberculosis when Doctor Eagle protested against making Folsom Prison a "sanitarium," and against the foisting "upon it the burden and care of the bacillus-bearing criminal," saying, "strict isolation must be resorted to." Here creeps in the first note of fear of the consumptive; a fear that was to grow until, before many years, the tuberculous were shunned as lepers, and treated shamefully and cruelly.

Now let us examine Doctor Stanley's solution of the problem, beginning in 1913 and continuing to date. From the first there was recognition of the double responsibility he faced:

1. The protection of the entire prison population—the public health problem.
2. The care or alleviation of the patient's illness—the medical and surgical problem.

The public health problem in the control of tuberculosis, as in the control of every infectious disease, resolves itself into case-finding and isolation. Fortunately for the prison population, Doctor Stanley had the active sympathy and support of a truly great prison administrator, Warden Johnston. The partnership of Doctor Stanley and Warden Johnston was to work miracles. A thorough physical examination of all entrants was established. This meant early case-finding. A special hospital for the tuberculous was prepared and equipped. This meant isolation.

The modern treatment of the sick tuberculous implies proper medical supervision, good hospital care, rest, and time. At San Quentin all these factors in recovery have prevailed. Good hospital care, with its implied sanitary surroundings, fresh air and an abundance of good food, have been supplied. The element of time has been taken care of by the judiciary. The rest factor has been supplied by hospital beds, plus the surgical-rest features of pneumothorax, phrenic interruption, thoracoplasty and other measures in the capable hands of Doctor Stanley and his associates, for rest of the diseased lung.

It might be well here to add two other historical notes gleaned from the record: In 1879 the death rate at San Quentin, mostly from pulmonary disease, was 17 per 1000. Today the death rate from tuberculosis is 2 per 1,000.

Anyone who knew San Quentin before the days of Doctor Stanley, and who knows the San Quentin of today, can see in the story of tuberculosis at that institution a wonderful example of what can be done with poor mental and physical material, in extremely unsatisfactory surroundings, when the problem is approached with enthusiasm, humanitarianism, and intelligence.

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Carl R. Howson, M.D. (1930 Wilshire Boulevard, Los Angeles).—To convey a complete picture of the horrible conditions existing in the prisons of civilized countries during even the past century it would be necessary to describe the indescribable. Only by a consideration of one phase at a time can we conceive of the situation.

Doctor Stanley has given us a startlingly graphic account of conditions as related to one communicable disease. He has sketched only the outlines. Actual experience with tuberculosis enables one to fill in some of the details.

He has, however, scarcely given proportionate space to his own accomplishments in remedying the formerly intolerable conditions and in providing adequate, modern, and humane facilities for the care of the tuberculous prisoners. Whatever one's criticisms of certain elements in our modern penalogic administration may be, there can be nothing but commendation in this case.

It is interesting to note that since the beginning of the century the reduction in mortality rate has been practically in the same ratio as that of the general population. With all modern aids, their present mortality rate still approximates that of the general population in 1900.

One wonders whether, with this group of individuals, it will decline any faster than the much slower decline it seems we have now to expect in the general death rate from this disease.

⁂

F. M. Pottenger, M.D. (Pottenger Sanatorium, Monrovia).—Doctor Stanley has given us an excellent history of tuberculosis in San Quentin.

It is very interesting to note that in the early years most of the tuberculosis was among Indians and Mexicans, and that it was the greatest cause of death in the institution.

In 1883, out of thirteen deaths eight were caused by tuberculosis; in 1885, out of twenty-nine deaths eighteen were caused by tuberculosis and three by scrofula; in 1889 and in 1904 one-half of all deaths were caused by tuberculosis.

In 1913 the picture changed. Doctor Stanley took charge of the work and brought to the institution modern health measures. He was especially tuberculosis-minded. A new hospital was built, and an examination of the chest of new arrivals was instituted. The result is most graphically shown. In 1913 there were sixty cases of tuberculosis in a population of 1910; and in 1934, after the measures for the control of tuberculosis had been existent for twenty years, there were only forty cases in a population of 6,400.

At the present time there is made a complete examination, with x-ray, of every entrant into the prison.

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* Part I of Doctor Stanley's paper (its text) appeared in last month's issue, December, 1938, on page 436.

Under the old condition of crowded unsanitary quarters such as existed fifty years ago, the death rate from tuberculosis was 17 per 1,000, while in 1937 it was 2 per 1,000. This still shows, however, that there is an exceptionally large number of the inmates of San Quentin who have tuberculosis. This makes the death rate from tuberculosis among the prisoners about equal to or a little greater than that of those who live in unsanitary quarters in their homes. While the death rate from tuberculosis in the general population of the United States is about 53 per 100,000, the death rate among negroes and Mexican city dwellers still runs from three to five times that figure; and in certain northern cities the death rate among negroes is seven times as great as that among the whites.

This contribution gives us a glimpse of what can be accomplished among an unfortunate group of people when treated humanely.

THE LURE OF MEDICAL HISTORY†

PLAGUE EPIDEMICS IN SAN FRANCISCO: HISTORICAL NOTES

By George H. Evans, M.D.
Berkeley

PART III*

THIRTY years have elapsed since the events here narrated occurred. Probably the dominating rôle played by the State Medical Association in conceiving and carrying to fruition the organization of the Citizens' Health Committee is forgotten, even by the older medical men. It was, I believe, the first time that the organized profession of California has ever undertaken an active and leading part in the carrying out of any public health emergency measure. Had not such a radical measure been undertaken, however, epidemiologists generally concede that a federal quarantine would certainly have befallen San Francisco.

PLAGUE: WHAT OF THE FUTURE?

What of the future? Has the work of the Citizens' Health Committee been productive of permanent results? Is San Francisco immune from the danger of further visitations of plague epidemics? At the last meeting of the Executive Committee of the Citizens' Health Committee the attention of the chairman was called to the necessity of some form of perpetuation of the Committee's activities if its work was to endure.

That present methods of eradicating rats in San Francisco are not entirely successful is indicated by the frequency with which they are observed. To what extent are householders generally observing the rigid rules laid down and strictly enforced in 1908 regarding the keeping and disposal of garbage and protection of all food from rodents? Of the rigid sanitary and building ordinances adopted in 1908 by the Board of Supervisors at the direction of the Citizens' Health Committee, how many of them are today strictly enforced?

PLAGUE TODAY WIDELY SCATTERED AMONG PACIFIC COAST RODENTS

The danger becomes the more apparent when it is realized that plague is today enzoötic in California over widespread foci among the wild rodents, particularly the ground squirrel. Foci of infection exist as far north as Modoc County, as far south as Los Angeles, as attested by the specimens sent to the State Hygienic Laboratory. Nineteen counties have been found to date to be infested with squirrel plague. Numbers of sporadic human cases have occurred in these infected counties, the last one in Tulare County in 1934.

PNEUMONIC PLAGUE OUTBREAKS IN OAKLAND AND LOS ANGELES

A particularly disquieting aspect of this squirrel infection is the frequency of the occurrence of pneumonic plague. The outbreak of the epidemic in Oakland in August, 1919, was clearly demonstrated to be of squirrel origin. It caused twelve deaths, two of whom were physicians. In the Los Angeles epidemic in 1924, out of thirty-two pneumonic plague victims thirty died.

Unsurmountable difficulties beset the epidemiologist in any attempt to overcome such widespread infection. Dr. W. H. Kellogg, Chief of the State Hygienic Laboratory, with his great experience on this subject, has truly said: "These endemic foci, constituted as they are of wild rodent infection, are, so far as anyone knows at present, permanent and everlasting."

DANGERS INHERENT IN THE ENDEMIC RODENT FOCI

It is apparent that there exists in California at present a natural reservoir of plague in these wild rodents, comparable to the historic foci in various Asiatic sections. Such endemic foci have more recently been established in Manchuria, accounting for the pneumonic epidemics which occurred there in 1910 and 1916. Plague may lie dormant in these endemic foci for considerable intervals between epidemic or pandemic spread. It is possible that in such intervals a relative immunity among the rodents may be established. That this may be true in California at present is suggested by the large number of infected fleas recently examined at the State Hygienic Laboratory which have been combed from the bodies of rodents free from infection. In the period from April 1 to August 1 of this year, of 3,416 squirrels examined at the State Hygienic Laboratory, only eight were found to be infected.

VIGILANCE AND PROTECTIVE MEASURES NEEDED

Discouraging though complete eradication of infection from these widespread endemic foci may be, we should be ever vigilant in the furtherance of preventive measures to protect our populous centers from such epidemics.

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† A Twenty-Five Years Ago column, made up of excerpts from the official journal of the California Medical Association of twenty-five years ago, is printed in each issue of California and Western Medicine. The column is one of the regular features of the Miscellany department, and its page number will be found on the front cover.

* In three parts. Part I appeared in the November issue, on page 383. Part II appeared in the December issue, on page 458.

An interesting sidelight on the infestation of rodent animals in California and other Pacific and Western States is revealed in the article, Sylvatic Plague, by Karl F. Meyer, M.D., and B. Eddie, M.A., which appeared in California and Western Medicine, December, 1935, on page 399.

If space permits, an interesting chapter on the part taken by the United States Public Health Service in the San Francisco plague outbreak, from the pen of Medical Director A. M. Stimson, will appear in the February issue.

The California Medical Association rendered an invaluable service to San Francisco in 1908. Has not the medical profession, through its state and county organizations, a higher responsibility to society by assuming a leading rôle in advancing public health protective measures than in its pursuit of its purely academic and economic activities?

78 The Uplands.

CLINICAL NOTES AND CASE REPORTS

DERMATITIS, URTICARIA AND AGGRAVATION OF NASAL SYMPTOMS FROM ORAL ADMINISTRATION OF POLLEN SUSPENSIONS

By Joseph A. Pollia, M.D.
Los Angeles

TOUART,[1] Black,[2,3] Gatterdam,[4,5] Kestern et al.,[6] Barksdale,[7] Stier and Hollister,[8] covering a period from 1922-1937, reported the use of pollens and their extracts by mouth in the treatment of hay fever and asthma. The amounts which were given varied from four minims of the 1:100,000 to 15 cubic centimeters of the 1:20 of the extracts. As a rule it was given daily, either continuously during the period of hay fever incidence, or for three to four days.

In none of these reports is there any note of the occurrence of any remarkable systemic reactions, even though the general trend of the conclusions was that oral administration of pollens and extracts was a very satisfactory method of treating the respiratory manifestations of allergy. Since 1933 the author, after a personal communication with Gatterdam,[9] began to administer pollen suspensions in physiological salt solution. Invariably, cases in an acute stage obtained relief by oral administration. However, out of a number of cases treated in this manner, three showed reactions with minute quantities of pollen suspensions.

REPORT OF CASES

Case 1.—A man, age forty-five, showed several questionable reactions from scratch and intradermal tests. However, the one from orris root was definitely positive. Three drops of 1:10,000 suspension of orris root in physiological salt solution was then taken once daily after breakfast, with instructions to increase one drop each day. After taking five drops once, the patient broke out with discrete patches of red, itchy dermatitis all over the body, which was relieved by ephedrin. The medication was discontinued for two weeks and the skin lesions completely disappeared; and when the medication was resumed, and he took five drops again, the same phenomenon occurred. After this second episode, further treatment was refused.

Case 2.—A female, age forty-six, with headaches and abdominal pain suggesting gall-bladder disease but without any evidence to confirm the diagnosis, was tested and showed multiple sensitivity. She was given a suspension of a mixture of 1:4,000 of each of the following pollens: Bermuda grass, burr, slender and western ragweed, and then instructed to make a 1:10,000 concentration by adding nine drops of water to one drop of the mixture. Because of the marked response to the testing, she was advised to take only one drop of this higher dilution once daily after breakfast and increase one drop each day. The patient was able to increase the dose up to seven drops of the 1:1,000. This dose provoked a severe rash and hives after each administration. Cutting the amount to one minim daily did not relieve the skin lesion and, therefore, all medication was discontinued for two weeks. When it was resumed with the same 1:10,000 ratio, she found that after taking even one drop daily there was a sensation of itching, and it was not until the frequency of this one minim was reduced to every third day that these symptoms were under control. She is still under treatment, and it is planned to increase the dose not oftener than once a week. The abdominal complex has not recurred since treatment was begun, and the headaches have been reduced in frequency and in intensity.

* * *

Case 3.—A male student, age twenty-one, suffering from repeated and long-continued attacks of severe sneezing, showed moderate reactions to Russian thistle, black walnut, desert and eastern ragweed. He was given a mixture of 1:4,000 pollen suspension of these materials, and instructed to take three minims of a 1:10,000 dilution made with water every morning after breakfast, and then to increase one drop daily. Profiting by previous experiences, he was instructed to increase one minim of 1:10,000 every third day. When taking five minims the simple, severe sneezing developed into a running nose and definite pharyngeal and laryngeal sensations. The medication was then discontinued when the symptoms ceased, although the sneezing remained. On resuming the treatment the same aggravation—running nose, dry cough—recurred. Then medication was again stopped, and on taking it the third time five minims produced the same symptoms again. Only when medication was administered twice a week, with increase of dosage once a week, was the aggravation of the nasal symptoms controlled.

IN CONCLUSION

Out of about one hundred patients treated with oral administration of pollen suspensions, three of them gave unexpected reactions following administration of varying amounts of 1:10,000 pollen units.

269 South Lake Street.

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[1] Touart, M. D.: New York State J. Med., 116:199, 1922.
[2] Black, J. H.: J. Lab. & Clin. Med., 12:1156, 1927.
[3] Black, J. H.: J. Lab. & Clin. Med., 13:709-713, 1928.
[4] Gatterdam, Eugene A.: Southwestern Med., (June), 1933.
[5] Gatterdam, Eugene A.: Southwestern Med., (April), 1934.
[6] Kestern, B. M., et al.: J. Allergy, 6:5, p. 431, (July), 1935.
[7] Barksdale, Irving S.: M. Rec., 144:1, p. 26, (July 1), 1936.
[8] Stier, R. F. E., and Hollister, Guy: Northwest Med., 36:166, (May), 1937.
[9] Gatterdam, Eugene A.: Personal communication.

SPONTANEOUS HEMATOMA OF THE ABDOMINAL WALL

FOLLOWING RESPIRATORY INFECTION

By William H. Snyder, Jr., M.D.
Hollywood

THE occurrence of acute abdominal symptoms during the course of, or following an upper respiratory infection, should suggest the possibility of a spontaneous hematoma in the rectus sheath. Little or no attention is given to this condition of the abdominal wall in textbooks of surgery, yet a number of such cases have been reported in the literature of the last two decades. Pain, tenderness, abdominal mass and signs of peritoneal irritation, following a coughing spell during a respiratory infection, can be the result of a spontaneous hematoma of the rectus muscle. The abdominal con-

TABLE 1

Author	Year	Type of Respiratory Infection	Duration of Abdominal Symptom	Preoperative Diagnosis	Operative Findings
Balgarnie	1919	Severe influenza—eight days	Two days	Appendicitis	Massive hematoma right rectus
Behan	1920	Influenza a few months before	Five days	Rupture, right rectus, ? appendicitis	Ruptured right rectus
Perman	1922	Bronchitis—two weeks, with dry cough	?	Left abdominal tumor	Left rectus hematoma
		Recent cough	One week	Left strangled ovarian cyst	Left rectus hematoma
		Cough for two weeks	Four days	Right strangled ovarian cyst	Right rectus hematoma
		Chronic bronchitis, months	One day	Twisted ovarian cyst	Left rectus hematoma
		Influenza—two months before	?	Twisted ovarian cyst	Right rectus hematoma
Wohlgemuth	1923	Coughing—three days	?	Ovarian tumor	Right rectus hematoma
Hilgenreiner	1923	Following attack of influenza	Four days	No preoperative diagnosis	Right rectus hematoma
R. I. Harris	1924	Ten days' attack of influenza	?	Appendicitis	Right rectus hematoma
Beck	Reported 1925	Severe bronchitis several days	?	Gall-bladder disease	Right upper rectus hematoma
Toft	1925	Bronchitis several weeks	Pregnancy (three weeks)	Ruptured pregnant uterus	Right lower rectus hematoma
Andrews	1925	Severe cough	Pregnancy (approximately one week)	Hydronephrosis Inflamed ovarian cyst	Right rectus hematoma
Blond	1928	Cough for six weeks	Three weeks	Left upper abdominal mass (Discoloration of skin)	Left upper rectus hematoma
Maxwell	1929	Severe cold—one week	Two hours	Twisted ovarian cyst. Premature separation of placenta with concealed hemorrhage	Left rectus hematoma
Deaver and Burden	1929	Cough, two months	Five weeks	Hematoma right rectus	Left rectus hematoma
Malpes	1930	Chronic bronchitis many years (Bleeder)	Three days		Left upper rectus hematoma
Vernon	1932	Spasms of coughing—fourteen years	Ten days	None	Left rectus hematoma
Mailer	1936	Influenza—two weeks	Twelve hours	Twisted ovarian cyst	Left lower rectus hematoma
Mainland	1936	Mild chronic cough	Five days	Twisted ovarian cyst	Right lower rectus hematoma
Henderson	1936	Mild influenza with dry cough			

dition is almost always misdiagnosed, and the patient is operated upon for a twisted ovarian cyst, appendicitis, strangulated hernia, or other acute abdominal emergencies, when the true condition is a rectus-muscle hematoma.

REPORT OF CASES

CASE 1.—The first case was that of a 36-year-old white, married female, who on March 4, 1937, immediately after a moderate coughing spell, complained of sudden pain in the right lower quadrant of the abdomen. The pain was constant and quite severe, but the patient was able to finish the preparation of her evening meal and to partake lightly of it. During the night the pain was so bad that she could not sleep, and toward morning she cried and moaned. It seemed to come in waves of increased severity, which would last for an hour or two, and then subside somewhat only to recur again after a short time. Any slight motion of the body increased the pain. The patient was more comfortable with the knees slightly flexed. There was no radiation of the pain. There was slight nausea, but no vomiting. There was a slight bowel movement twelve hours after the onset of the pain. There were no urinary symptoms. The last menstrual period was normal, and occurred three weeks previously. The patient was just getting over an upper respiratory infection which had lasted about ten days, and was associated with a moderate cough.

Ten years previously the patient had been operated upon for appendicitis and salpingitis, although she was not sure what had been done. Since that time she had been quite well except for one attack of lower abdominal pain and fever, which lasted a few days. This occurred about a year previously. Her general health had been excellent. She had several incomplete abortions many years ago, but no pregnancies during the last ten years.

Fifteen hours after the onset of pain she was sent to the Hollywood Hospital. Examination at this time revealed a well-developed and well-nourished woman with agonizing right lower quadrant abdominal pain. Her temperature was 98.8 degrees Fahrenheit, pulse 78, blood pressure 120/80. She had a rather loose cough with a few moist râles at the left base. The abdomen was rigid in the right lower quadrant, with extreme tenderness extending fairly high on the right side. The left side was comparatively nontender and soft. Peristalsis was audible on the left, but not on the right. Pelvic examination revealed a mass about the size of an orange in the right vault which was very tender. The extreme abdominal tenderness made bimanual examination unsatisfactory. Laboratory examination revealed a white blood count of 16,400, a red blood count of 3,900,000. The Schilling showed eight stabs, fifty-eight segmented forms, with no juveniles. The polymorphonuclear leukocytes represented 85 per cent of the count.

The patient was operated upon, with a diagnosis of twisted ovarian cyst. The old midline scar was excised, and just below the dermis the tissues were hemorrhagic. As the fascia was cut and the undersurface of the right rectus exposed, a fresh blood-clot was found to extend downward properitoneally into the pelvis. The mass was about the size of a large orange. Examination of the rectus muscle showed it to be torn in places with extensive areas of hemorrhage. Several bleeding points were ligated, and the deep epigastric artery and vein were ligated above and below the area of hemorrhage. The hematoma was removed and two Penrose drains were inserted. The patient made an excellent convalescence, and the wound healed firmly.

* * *

Case 2.—The second case is that of a 50-year-old white female, seen at the Los Angeles County Hospital. She was recovering from an attack of "influenza," and after a severe coughing spell she experienced a sudden distressingly sharp pain in the left lower quadrant. The pain persisted and was of a severe aching character, not colicky. She had had no such pain previously, and no other important symptoms. She had had a bowel movement the previous day, and enema on admission produced good results. There was no history of bloody or tarry stools or vomiting. The only important feature in her past history was a panhysterectomy two years before for a "tumor of the cervix."

Physical examination revealed a fairly well-developed and well-nourished elderly female, rather acutely ill. She still showed signs of a recent respiratory infection, a mild rhinitis and pharyngitis, and some râles in her right base posteriorly. Blood pressure was 160/100. Her abdomen was of normal contour, but showed a soft tender mass about the size of a fist in the left lower quadrant. There was no tympany, rigidity or distention. Pelvic examination showed absence of uterus and cervix. There was no induration of the broad ligament. Rectal examination was entirely negative.

Laboratory examination showed a leukocyte count of 8,600 with 66 per cent polymorphonuclear cells. The urine was negative except for a few granular casts.

Preoperative diagnosis was incisional hernia with incarcerated omentum. There was a mass over the left lower quadrant midway between the anterior superior spine and the umbilicus, and about two inches below a line drawn between these two points. A left rectus incision was made over the mass. The fascia was incised and its edges retracted and separated by blunt dissection from a mass immediately below the fascia. The dissection revealed a blood-clot about 4 by 5 centimeters in diameter. The clot was removed and the space mopped clean. Then it could be seen that the fibers of the left rectus were ruptured, apparently, as cleanly as though cut with a knife. This transverse rupture extended about two inches in width. The ends of the ruptured muscle were sutured with plain catgut and the dead space closed. The fascia and skin were closed. The patient made an excellent recovery.

COMMENTS ON THE LITERATURE

The cases of hematoma of the rectus muscle listed in Table 1 have been culled from the literature. Each case recorded was either suffering from an upper respiratory infection at the time or had recently been affected: furthermore, all were operated upon for an acute abdominal condition, and in only two cases of the twenty-one cases was the preoperative diagnosis made correctly.

A study of these cases reveals that:

1. Twenty-one cases of massive hematoma of the rectus muscle following respiratory infection have been recorded in the literature.

2. In nineteen out of twenty-one cases there was a mistaken diagnosis.

3. Two cases were considered preoperatively as appendicitis.

One case was considered preoperatively as acute gall-bladder disease.

One case was considered preoperatively as ruptured pregnant uterus.

Ten cases were considered preoperatively as twisted ovarian cysts or ovarian tumors.

4. The condition occurred in patients from eleven years of age to seventy-three years of age. It is found predominating in female patients. Three were pregnant.

These cases represent only a special group of rectus hematomas occurring in patients with a respiratory infection. The cause of these hematomas can best be explained as the result of a general infection, producing degenerative changes in the rectus muscle. That degeneration of muscles is a result of a general infection has long been believed. Zenker described it as occurring in typhoid. Rost (Culbertson) has reported two such cases. The proof that influenza is a causative agent of muscle degeneration appeared in the literature following the great influenza epidemic of 1917. Klotz reported fourteen autopsy cases showing degeneration of the rectus muscle, of which six were ruptured. Gage reports Wolbacks necropsy findings of rectus muscle degeneration in nine cases. Beals Blanton and Eisendrath reported eight cases of hemorrhages and rupture of the rectus muscle in autopsy of patients dying of influenza.

IN CONCLUSION

Summarizing the pathological changes reported by these authors, we find that there is a primary degeneration of muscle tissue with spontaneous rupture followed by hemorrhage. If infection takes place, it is of secondary nature. The one constant change accompanying the degeneration is the early loss of staining qualities in the muscle fibers. Later the areas take on a waxy appearance and finally either rupture or end in scar formation. The pathological changes may occur anywhere in the rectus muscle, but are usually found in the region between the umbilicus and the pubis. They were also found in other muscles with less frequency.

SUMMARY

1. Two cases of upper respiratory infection developing massive hemorrhage of the rectus muscle

which produced symptoms and signs suggestive of an acute abdominal condition are reported.

2. A summary of similar cases in the literature is furnished.

3. An explanation for massive hematoma in the rectus muscle, occurring in upper respiratory conditions, is presented by a study of autopsy findings of the influenza epidemic of 1917.

4. The practical surgeon is enjoined to consider rectus-muscle hematoma in cases of the acute abdomen following a respiratory infection.

6777 Hollywood Boulevard.

FOOD POISONING APPARENTLY DUE TO HOLLANDAISE SAUCE

By J. C. Geiger, M. D.
and
W. J. Ragan
San Francisco

THREE separate and unrelated outbreaks of food poisoning were reported to the San Francisco Department of Public Health. The illness was estimated to have affected several hundred persons. The third outbreak was reported in December, 1937. All the outbreaks occurred in a first-class hotel; and though suspicion was cast upon the "Hollandaise sauce" in each, none of the sauce was available for examination except in the last. In this outbreak twenty persons were affected.

The clinical evidence appeared conclusive for food poisoning—namely, symptoms of nausea, abdominal pain, vomiting, and diarrhea being present two to six hours after the meal. Likewise, the epidemiologic evidence appeared conclusive as to the "Hollandaise sauce" being the causative food factor. The resulting laboratory examination of the "Hollandaise sauce" was interesting. The pH electrometrically was 4.65 after being several days old, but in fresh material the pH was 6.31. Investigation further indicates a wide discrepancy among the chefs of San Francisco hotels as to the manufacture of the sauce, the main difference being the use of vinegar, which was indeed rare, if used at all. The sauce generally consists of egg yolk, melted butter, salt, cayenne pepper, with a small amount of lemon juice, and no vinegar, strained through cloths. This composition, with its pH, coupled with the fact that the sauce may be "incubated" or kept warmed on or in a steam table for twelve to eighteen hours, suggests that the presence of demonstrable hemolytic staphylococci and the production of gastro-intestinal irritant substances, may be due entirely to growth of the organisms. The causative sauce revealed numerous colonies of hemolytic staphylococci, which organisms, when grown in sauce made similarly, proved toxic when injected into laboratory animals. Examinations of stools and throat cultures of the food handlers involved in the manufacture of the causative sauce were negative for organisms of the paratyphoid- enteritidis group or for hemolytic staphylococci.

On the basis of the epidemiologic and laboratory evidence it would appear that sauces manufactured as, and containing such materials as in the "Hollandaise" recorded, and stored or incubated for hours in kitchens, offer a suitable vehicle for the production of food poisoning in humans. From the laboratory evidence one might deduce that specific contamination may have been general, such as from ingredients, hands, apparatus, straining cloths, skin or the respiratory tract, and that multiplication of the bacteria was due to the excellence of the medium and of the incubation.

Curiosity as to the source of hemolytic staphylococci cannot be readily or reasonably met, since these organisms are not uncommon in the types found on the skin and in the respiratory tract of man. Since the advent of this group of bacteria into the realm of food poisoning in man, any laboratory evidence so obtained may have to be regarded as circumstantial, and closely allied with the epidemiology. Further, field investigations as to the incidence of hemolytic and other staphylococci in normal foods and their entero-toxico-genicity appear necessary. There is no doubt that the organisms are common and exceedingly difficult to eliminate. Therefore, the question naturally arises as to their appearance in foods not involved in outbreaks of food poisoning. Moreover, what conditions, artificial or experimental, must be linked to have poisonous products produced?

Conclusions. An outbreak of food poisoning, affecting twenty persons, is reported in a first-class hotel from so-called "Hollandaise sauce." The epidemiologic, bacteriologic, and toxicologic evidence appears conclusive as to the food and to the causative organism, hemolytic staphylococci. The specific source of the contamination was not determined. Executive orders, however, of the San Francisco Department of Health now prescribe exact directions for the manufacture, storage and use of such sauces in hotels and restaurants.

101 Grove Street.

ALLERGY TO LIVER EXTRACT

By W. E. Diefenbach, M. D.
and
Anton S. Yuskis, M.D.
La Jolla

ALLERGY to liver extract, acquired as a result of injections, is reported only four times in the American literature and five times in foreign literature. In the American reports, Metzger[1] in 1931 described an asthmatic reaction following the administration of liver extract. Held and Goldbloom[2] described a reaction characterized by an urticaria. Criep[3] described a marked reaction consisting of severe asthma and a generalized urticaria, and Krantz[4] described a generalized urticaria following the parenteral administration of liver extract.

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[1] Metzger, Edward: Bronchial Asthma Caused by Liver and Liver Extract Diet in a Patient Suffering from Primary Anemia, J. A. M. A., 96:110 (Jan. 10), 1931.

[2] Held, I. W., and Goldbloom, A. A.: Addisons-Biermer's Anemia (Pernicious Anemia); Report of a Case Showing Allergic-like Phenomena to Liver Extract, J. A. M. A., 96:1361-1363 (April 25), 1931.

[3] Criep, Leo H.: Allergy to Liver, J. A. M. A., 110:506 (Feb. 12), 1938.

[4] Krantz, Clement I.: Anaphylactic Reactions Following Medication with Parenteral Liver Extract, J. A. M. A., 110:802 (March 12), 1938.

In the foreign literature Engel[5] in 1933 described an immediate reaction consisting of marked weakness, imperceptible pulse, vomiting and a skin rash. A short time later Grün[6] described reactions characterized by a generalized erythema, dyspnea, weakness and vomiting. Roovers[7] reported several instances in which asthma, urticaria and other unpleasant reactions developed. Lasch[8] described two cases of allergy to liver consisting chiefly of urticarial manifestations. Schlesinger[9] reported one of angioneurotic edema. The purpose of this report is to bring attention to the fact that reactions do occur after parenteral liver therapy.

REPORT OF CASE

Mrs. W. H., a white female, age 65, complained of weakness, sore tongue, abdominal discomfort and sporadic attacks of diarrhea. Her past history was negative and she had never received any injections of horse serum.

The only essential abnormal physical findings were: smoothness of the edges of the tongue and a diminution of vibratory sense in the lower extremities. Examination of the blood revealed: Hemoglobin 60 per cent (Dare), erythrocytes 2,900,000 cells per cubic millimeter, leukocytes 5,000 cells per cubic centimeter, polymorphonuclear leukocytes 63 per cent, lymphocytes 30 per cent and monocytes 6 per cent. The erythrocytes were well filled with hemoglobin, but with moderate anisocytosis, macrocytes predominating and poikilocytosis. The leukocytes showed no changes from normal aside from being reduced in number. There was a definite achlorhydria.

From these observations a diagnosis of pernicious anemia was made and liver therapy by injection was instituted. Dilute hydrochloric acid during meals was also given. A good response resulted as the diarrhea, soreness of the tongue and abdominal discomfort subsided. The patient received liver extract (Lederle's) intramuscularly at intervals of seven days for three months without any reactions. Clinical improvement was marked and the patient was instructed to take liver medication orally. She returned to her ranch in Montana and was not seen again for a period of eight months. When she came back she complained of feeling tired in her thighs and legs, as well as of general weakness. Parenteral liver medication was again instituted, and after a short time her condition improved. About fifteen minutes after the fourteenth (total) injection a marked reaction developed consisting of anxiety, accelerated pulse rate, a generalized feeling of warmth which progressed into a moist perspiration and finally a generalized urticaria. Epinephrin was given immediately and relief resulted shortly. Intramuscular injections were discontinued and a liver concentrate by mouth was substituted. At present the patient's health has been restored to about normal.

The cause of these reactions is not entirely clear. Milbradt[10] found that the preservative used which contained the benzine ring was capable of producing these reactions. According to Coca, quoted by Criep, the specific antibodies produced in acquired allergy result from unusual exposure, such as by injection to an unusual substance, as worms, insulin, solution of posterior pituitary and liver. In direct contrast to the specific antibodies found in natural allergy, such as bronchial asthma, hay fever, etc., the specific antibodies in acquired allergy are of short duration, and their presence is usually associated with the finding of other antibodies, such as precipitins and anaphylactic antibodies. Criep in his tests found the serum to show the presence of precipitins against liver extract up to ten months after the initial reaction, but failed to demonstrate the presence of anaphylactic bodies to liver in the serum during a similar period of time. He further found that this type of acquired allergy could not be produced experimentally.

IN CONCLUSION

An allergic reaction apparently to liver extract was observed. This acquired sensitivity is to an organ and not to a biologic source. These reactions are rare, but it should not detract one from the use of liver extract. To the contrary, it should make one be on the lookout for evidence of this type of sentitivity.

7819 Girard Avenue.

I should like particularly, at this point, to make it clear that the Public Health Service has no jurisdiction whatever over local health matters entirely within the states. You probably recall that the Constitution of the United States reserved to the states all powers not specifically delegated by the Constitution to the Federal Government.

Control over local health matters wholly within the states was not among the powers delegated to the Federal Government by the Constitution.

I also wish to emphasize the fact it is not the aim of the Public Health Service, in carrying out this or any other program, to establish a huge federal machine which will have control over all state and local health work in this country.

It is our purpose, on the other hand, to aid the state and local authorities in developing further their own organizations and programs.

The last thing we wish to do is to break down the local sense of proprietorship and the sense of responsibility, among the local people, for support, financial and otherwise, of their own institutions.—C. E. Waller, United States Public Health Service.

In the more than thirty years since the first bureau of (governmental) research was established, American governments have come a long way on the road to respectable public service. Citizen agencies of various sorts have contributed to that progress, and the modern public official, in spite of handicaps, has played a creditable part. The basis of much of this reform has been facts, and "getting the facts" has been the contribution of research.—Lent D. Upson, *The Annals.*

It is the opinion of those who best understand the physical system that if the physical laws were strictly observed from generation to generation there would be an end to the frightful diseases that cut life short, and of the long list of maladies that make life a torment or a trial, and that this wonderful machine, the body—this "goodly temple"—would gradually decay, and men would at last die as if gently falling asleep.—Mrs. Sedgwick.

Health is certainly more valuable than money, because it is by health that money is procured; but thousands and millions are of small avail to alleviate the tortures of the gout, to repair the broken organs of sense, or resuscitate the powers of digestion. Poverty is, indeed, an evil from which we naturally fly; but let us not run from one enemy to another, nor take shelter in the arms of sickness.—Johnson.

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[5] Engel, K.: Anaphylactic Reactions in Liver Preparations: Case of Pernicious Anemia, Bol. Assoc. Med. de Puerto Rico, 25:326-329 (May), 1933.

[6] Grün, G.: Allergic Reaction to Injection of Liver Preparation, Orvosi Netil., 77:736-737 (Aug.), 1933.

[7] Roovers, J. J. C. P. A.: Treatment with Liver Extract (Pernaemon): Unpleasant Symptoms After Injections, Nederl, tijdschr. v. geneesk., 79:5148-5149 (Nov. 2), 1935.

[8] Lasch, Fritz: Wien med. Wchnschr., 86:126-127 (Feb. 1), 1936.

[9] Schlesinger, Wilhelm: A Case of Angioneurotic Edema from Oral Administration of Liver in Pernicious Anemia, Wien. med. Wchnschr., 80:696 (May 17), 1930.

[10] Milbradt, W.: Ueber Eine eigenartige scheinbare Allergic gegen Leberextrakt, Dermat. Wchnschr., 101:1595 (Dec. 21), 1935.

BEDSIDE MEDICINE FOR BEDSIDE DOCTORS

An Open Forum for brief discussions of the workaday problems of the bedside doctor. Suggestions of subjects for discussions invited.

RABIES: ITS PRESENT-DAY PROBLEMS*

I. THE CONTROL OF RABIES IN SOUTHERN CALIFORNIA

George Parrish, M. D. (2188 Live Oak Drive, Los Angeles).—The fundamental principles for the control of rabies in Southern California are about the same as they are in any other part of the country; making allowances for variations which occur with the differences in size of the many subdivisions and with the types of people and the extent of their education. Southern California, unfortunately, has the reputation of having more visionaries of more varieties running loose, than live in all the rest of America. These people appear and take part in public discussions, make false, vindictive and vicious statements, assassinate character by suggestion, treachery and innuendo. They are against everything that benefits mankind, especially if it has to do with medicine, and no amount of reasoning or evidence can or will convert them. They make claims and statements as truths which are devoid of reason or judgment, and which are not supported by the United States Public Health Service, or the state or local health departments. They are mavericks grazing in the pastures of ignorance and willing to remain there.

Relation of Sentiment and Emotionalism to Dogs and Rabies.

A medical authority says a dog has rabies; some childless, husbandless, dog-loving female says the authority is wrong, the dog is only suffering from mental worry, something that will not trouble her! The authority makes a scientific examination and verifies his diagnosis. A fanatic stands outside of the kennel, sees the dog having convulsions, hears its peculiar or characteristic howl and says "worms." She doesn't say whether she is referring to herself or the dog.

If they have ever read any authentic public health literature whatsoever they fail to show it. To them the Rockefeller Foundation is just a figure of speech, while Johns Hopkins is a character in mythology. In their learned discussions they quote among others Dr. Walter R. Haydon of England, a rabid "anti" on everything, who was tried for manslaughter because, in his ignorance of diphtheria, he permitted a child to die unnecessarily; Dr. William Collins, a favorite of theirs, wrote his learned discourses in 1881; Dr. Philip Ricord, was a really fine physician, but he wrote in 1867. They quote other doctors who practiced before the discoveries of Louis Pasteur enlightened us. Occasionally they repeat the words of some modern authority, but when they do, they resort to that time-worn trick of using just those words that fit their purpose and in such a manner as to always distort the meaning which the writer intended to convey.

We are living in an age of exaggerated sentimentality, and this silly mental agitation is attempting to prevent proper means being taken for the promotion of human life. When a man or a woman gets to a point where he loves his dog more than he does his child, when he believes his dog should run at large without restraint and that the child should be locked up if it interferes with the liberty of his dog, then that person is only one jump behind the person who is already institutionalized. Citizens of this particular type have a peculiar social standing, and belong to no special sect, cult, religion or political faith. They are very clannish, avoid others and are shunned by the more educated people.

Unusual Conditions in Southern California.

The great majority of citizens residing in Southern California are fine, high-class, thoughtful persons; but, unfortunately, the reasonable, sane-thinking people—the majority—are too busy with their own private affairs and in making money, to devote any of their time to civic affairs; whereas the average fanatic has no private affairs, but attends to the business of everyone else.

The foregoing preamble is presented to show the type of persons and the obstacles the Southern California health departments have to meet and contend with.

Prevention of Rabies Not an Easy Problem.

The prevention of rabies is often a difficult, expensive and unsatisfactory procedure. On the one hand public health authorities are handicapped by the fact that rabies in human beings occurs infrequently and, consequently, there appears to be no urgent need for waging constant warfare against the malady; on the other hand, too many of the thinking public take too much for granted, believing they will be protected by public officials whether they take an interest or not. Coupled with these handicaps there are many dog owners who are wholly indifferent to the health and welfare of their neighbors.

If a child made a daily practice of running on his neighbor's lawn, tramping down the shrubbery, breaking the flowers and tearing up the grass, he would be soundly spanked and his parents would be called upon to pay the damages. He would probably be regarded as a problem child, and the social workers would be sitting on his doorstep; but these self-styled dog lovers fly into a rage if some regulation is suggested for the dog.

Statistical Data for Los Angeles.

The difficulties encountered in antirabic control can best be presented by means of statistical data. In the first place, Los Angeles has no ordinances which apply to the control of the dog. The dog is monarch of all he surveys. He can tear off your arm or your child's leg, but nothing can be done about it, for he, under the law, is entitled to a second bite before action against him can be taken. A man may be charged with mayhem and put in jail if he bites a fellow who is beating him up; but he is only a man. Southern California needs a comprehensive and complete law which will take care of the dog throughout the year.

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* In this issue, see press item on Rabies Problem in Santa Clara County, on page 67.

Suggestions Concerning Legal Provisions.

There should be at all times a systematic collection and elimination of all ownerless or stray dogs. No dog should be permitted on any public highway or in any public park unless on a leash, not exceeding six feet in length. A dog accompanied by his owner, if said owner is more than fifteen years of age, may run without leash provided the district is not under special dog quarantine. The owner of a dog, which, in violation of the law, is running at large and bites an individual, should be held legally responsible for all damages.

Any dog roaming at large without leash shall be picked up and taken to the pound. If licensed, the owner shall pay five dollars to reclaim him; if unlicensed, he shall pay for a license plus five dollars for failure to observe the law. There should be a graduated dog license fee. This should be $2 a year for the male, and $4 a year for the female dog, provided this fee is paid during the first three-month period during the year. One dollar extra should be added to this fee if it is not paid until the second quarter, making it $3 for the male and $5 for the female; another dollar should be added for failure to pay until the third quarter and still another dollar for the fourth quarter. This penalty imposed would not only cause owners to pay more promptly, but it would cause more worthless curs to be turned over to the authorities. The leash law would also help thin out the dog population.

People living in one room or in a small apartment in a crowded community, under these regulations, would soon tire of caring for their dogs and get rid of them. At present, most of these people only keep a dog because they do not have to pay any attention to him. They open the door at 6 a. m., the dog disappears until 6 p. m., and gets all his meals out of the neighbors' garbage cans.

Rôle of a Humane Animal Department.

In the collection of dogs the Humane Animal Department should make a monthly report to the state and local health officer covering his activities. In a rabies outbreak when a quarantine regulation has been declared by the state or local health officer, the agency which picks up and impounds the dogs should automatically pass under the directorship of the health officer until the quarantine is lifted. In my humble estimation, the state health officer, and he alone, should place a quarantine on dogs. In most instances he would do so at the request of the local health officer, or it would be done based on reports received by him. This regulation should be inviolate.

According to the United States Public Health Service, one of its most difficult obstacles to overcome in connection with public health is its inability to get scientific and accurate facts to the people. Politics, prejudices and ignorance do much to sway public opinion and distort and mask the truth. The success of preventive medicine in eradicating any communicable disease depends ultimately on the public backing. Medical knowledge is useless unless the moral support of the community is strong enough to translate it into action.

To summarize.

In conclusion, city ordinances or state laws sufficiently strong should be drawn that will control any situation that arises provided they are enforced. The responsibility for bites should be placed squarely upon each dog owner. Moreover, a city should be reimbursed or fully compensated for its financial outlay in preventing human and canine rabies. There should be an all-year effort to rid the community of stray and unlicensed dogs.

The writer believes that each person bitten should receive compensation, whether the bite is provoked or unprovoked. A dog bite frequently involves pain, fright, torn clothing, a doctor's bill, and sometimes hospital treatment, and is a distressing experience. Moreover, a course of prophylactic injections is an ordeal, particularly for children. If the owners of biting dogs were sufficiently penalized, there would be a marked and rapid reduction in such occurrences. Occasionally, resorting to a shotgun quarantine is necessary and satisfactory: it immediately awakens the indifferent public to a sense of actual responsibility. In brief, it is a question of *Science* vs. *Ignorance*—*Sanity* vs. *Insanity*—of the *Majority Public* vs. a *Fanatical Few*.

* * *

II. WHY WE HAVE RABIES IN OUR COMMUNITY, AND WHAT TO DO ABOUT IT

J. L. Pomeroy, M. D. (330 North Broadway, Los Angeles).—It has been stated that, since 1922 up to 1937, we have had in California about 13,000 cases of rabies, and that California leads all other states in the number of such cases. It has been further stated that Los Angeles County heads the list of all counties in the State of California, having over 9,000 out of the total. It seems necessary to review some of the reasons why this situation exists, and what might be done about it.

Statistics for Los Angeles County.

During the last sixteen years our department [Los Angeles County Health Department], which covers about one-third of the total population of Los Angeles County, has averaged 210 positive heads per year. This means that there were approximately 356 positive heads for the remainder of Los Angeles County. From records in our department the first serious outbreak of rabies occurred in 1922-1923, with a maximum of about 850 cases. The disease dropped during the following four years to below 300 cases per year. It again rose to a new level of between 500 and 600 cases from 1928 to 1931, when it again fell for two years to nearly 300 cases per year. Beginning in 1932 it has climbed steadily, increasing each year until it reached 1,800 cases during the year 1937. During 1938, for the County Health Department area, the disease reached a new peak of 26 positive heads during the fifth week. It has declined slowly until the twenty-fourth week, when there were 8 cases. During the past eighteen months there have been five human deaths in the entire county.

It can thus be seen that rabies is one of the more important communicable diseases in health department work. During 1937 nearly $60,000 were expended in fighting this disease. There were 789 persons who received the Pasteur treatment, and over 2,000 individuals had their wounds cauterized with fuming nitric acid.

In numbers of cases handled during 1937, for comparison I give a list of certain other important contagious diseases, notably, diphtheria, 168 cases; influenza, 887; pneumonia, 547; syphilis, 924, and poliomyelitis, 53. There are few diseases communicable to man which have as their carrier an animal with four legs capable of traveling many miles, leaving here and there future foci through the animals it has bitten. Recently, for example, one dog in the course of its travels bit 11 licensed dogs, 3 unlicensed dogs, 1 bull, 4 cows, 21 goats and 5 persons.

Sources of Infection.

Various theories have been propounded as to sources of infection in California. I have heard it expressed many times during the past thirty years that a reservoir exists in the mountains of California, and domestic animals are constantly being infected from this so-called reservoir. Evidence shows, as recorded in the March 26, 1938 State Bulletin, that beginning in the early history of California to date, known cases of rabies have occurred among wild animals in California. At least this factor must be borne in mind. I cannot precisely evaluate the importance of this factor, but I am inclined to believe that in Los Angeles County it does not play a marked rôle. Nevertheless, it should not be ignored. I personally believe that the disease follows the well known biological rule of periodic increases in virulence with rapid spread. It is a well known fact that only about 16 per cent of human beings bitten would develop rabies, and surely with the fur-bearing animals the percentage is much less. And as to the question of carriers we have little knowledge indeed. So far there is no evidence to support the presumption that carriers exist in relation to rabies.

Another consideration that, in my opinion, is important in Southern California particularly is the tremendous tourist traffic, introducing dogs and other animals from all parts of the United States continually. For one reason or another many of these dogs become strays, and unquestionably do introduce rabies not infrequently into our territory.

Control Measures.

Various control measures have been recommended in the handling of rabies outbreaks, and during the last twenty-five years the following have been tried: control of the dog population by requiring an annual license; provision for the impounding and the humane destruction of all unlicensed dogs; and quarantine of all dogs in areas where rabid animals have run at large. Muzzling has never been thoroughly tried in our county, although it has been attempted from time to time. The organization of a County Pound system was first attempted by the Board of Supervisors through contract with private humane animal societies. For various reasons which will be discussed later, this was abandoned approximately two years ago with the creation of a county poundmaster, who collected all stray and unlicensed dogs with his own men and trucks; but the county still continued to house the animals thus collected at private humane animal pounds. The destruction by shooting of all animals at large has never been done in Los Angeles County except during a concurrent hoof and mouth disease outbreak many years ago. Needless to say, rabies vanished within a very short time following the installation of this ruthless campaign. At least there is one rapid method of controlling rabies in the shooting of all dogs found at large during a quarantine.

Quarantine has been successful in the past in controlling relatively small isolated outbreaks. A few years ago in the district known as Belvedere a rigid quarantine was placed under order of the State Board of Health, and in a period of six weeks some 5,000 dogs were captured and destroyed. Rabies was wiped out very promptly.

Problems of Large Areas.

When we come to deal, however, with the situation where a county with a large city such as Los Angeles, likewise infected with rabies, cuts through the heart of the most populated area, the problem has different aspects. Physically, all of the forty-four cities in Los Angeles County are contiguous to the unincorporated areas, therefore epidemiologically, the entire county is the logical field for the spread of the disease as well as the enforcement of control measures. There is no doubt whatever that rabies has been endemic in Los Angeles City at least since 1921, and infected animals have acted as feeders to the remaining area in Los Angeles County.

The present quarantine was the result of the efforts made by Dr. George Parrish, health officer of Los Angeles City, and myself in the spring of 1938. We came to the conclusion that, to be effective, the quarantine must cover the major populated areas in the entire county. In spite of inherent difficulties in enforcement of any quarantine measures such as this is, the records show that, since the spring of the year and following the enforcement of the quarantine, rabies has declined. *It is possible* through a quarantine measure to stamp out rabies, but the measure will never succeed as effectively as it might if we had the hearty coöperation of the people.

Organized Opposition.

The chief reason, in my opinion, as to why we have rabies is that this disease and its resultant enforcement measures inevitably arouses an adverse emotional condition because it disturbs man's relationship with his pets, and because there are large numbers of persons actively engaged in and making a living out of the handling of pets, the organizing of shows and all of the rest of the picture that accompanies this part of human life.

The first real obstacle encountered was an attempt through the courts to strike at the fundamental law. An injunction was obtained by a certain dog organization in Los Angeles which restrained the health officers from enforcing the law for a period of several weeks, during which time, of course, dogs were permitted their freedom. Fortunately for the case of public health, the court decided finally against the dog association, and for the cause of public health. This decision, which is an important one, has been published in a previous issue of this magazine. The attack was directed purely on the interpretation of the law, but it is important to bear in mind that the organization which fostered the attack believes that the licensed dog should be exempt from any quarantine measure. The Court held that: "It is true that dogs are property; that the owners have a property right therein but, like other property, they must be kept by their owners in such a manner that they will not become a menace to other animals or to human beings."

It is important to review the extent locally of the opposition, the effect of which is that rabies may not be stamped out in Southern California. In the first place, there is the natural lack of a sense of conviction of the real danger to any individual concerning rabies. After all, in a large population comparatively few people see a rabid dog, and hence lack personal experience. Furthermore, by comparison, deaths from automobile accidents and other causes are so much greater and so common that it is difficult with many citizens to convince them of the necessity of keeping their particular dog under control. Again, we are to a certain extent to blame because of a lack of an adequate system of education of the public in matters of this kind. I have been amazed to discover the fact that a great many people know little concerning the disease rabies. It is quite apparent that California as a whole lacks a real constructive system of health education in our public school system. Until this is accomplished, health departments can do little. Education in the humane treatment of animals is a byword among school children, but education in communicable diseases is, in my opinion, to a large measure ineffective throughout the state, at least in relation to animal diseases.

Then we have a group called the Antivivisectionists, who are most vehement and most aggressive in their interest to protect dogs and other animals. However, in regard to rabies it is interesting to note that this opposition has softened very considerably in regard to our recent rabies control measures.

Next is a large group which, under the name of Humane Societies, is really interested in the matter from a business standpoint—the impounding and sale of animals. Coupled with this is the group of pet shops and similar organizations whose business is disturbed by any quarantine order.

Recognizing the peculiar emotional reaction which is bound to result in serious opposition in quarantine measures in handling rabies, the writer believes that, as a public policy, the present quarantine in Los Angeles County should not be lifted until local ordinances are made permanent relative to curbing the past freedom enjoyed by the dog.

Author's Suggestions.

We propose the following program:

1. A permanent campaign rigorously enforced in relation to picking up stray dogs.
2. A permanent ordinance requiring dogs at large off the owner's property to be only on a leash.
3. Research looking for a more effective vaccine against rabies, as well as efforts to standardize the effectiveness of the present material used for Pasteur treatment to make sure that it is potent.
4. Educational efforts, particularly among the younger group of people throughout the county.

In Conclusion:

It is the current belief in our department that only through the development of a really efficient protective vaccine against rabies can a material advance in the method of handling this disease be developed. Further, we believe that the State or Federal Government should standardize the effectiveness of the present material on the market in common use for the administration of the Pasteur treatment, to make sure that a potent material is available. Also, we believe that the present state law known as the Rabies Act should be modified and brought up-to-date, as certain aspects of this law are not working properly.

* * *

III. IS RABIES TRANSMITTED THROUGH MILK?*

K. F. Meyer, M. D. (George Williams Hooper Foundation, University of California, San Francisco).—It is a well known fact that rabies may be conveyed to herbivorous animals through the bite of rabid dogs, wolves or coyotes. Reports on the epidemic distribution of this disease in herds of cattle are by no means infrequent. Occasionally, milk secreted by a cow, which subsequently is proved to have suffered from rabies, is offered for sale and is consumed raw by a large clientele of the dairy. One is then confronted with the pertinent question: Should the individuals who have ingested the milk be subject to antirabic treatment? A critical evaluation of the available information, in the light of newer knowledge and the formulation of a definite answer, appears imperative. To begin with, it is noteworthy that the views relative to the infectiousness of milk derived from rabid animals have, in the course of years, undergone a number of changes.

Comments on the Literature.

At the beginning of the nineteenth century, the prevailing views concerning the harmfulness of milk derived from rabid animals were changed, when numerous feeding experiments yielded negative results. *Moreover, a careful perusal of the available literature failed, and has failed to record a single case of human rabies which has conclusively followed the ingestion of milk from a rabid cow or animal.* The extensive and fundamental researches by Pasteur and his associates, however, furnished proof that the virus, although present in a concentrated amount in the central nervous system, may be found in certain glands and their secretions. In particular, the salivary and the lacrimal glands, the pancreas and, occasionally, the mammary glands may contain the infective agent. Furthermore, it must be recalled that, just as in foot and mouth disease, the virus may be accidentally transferred and mixed into the milk after it has been collected from the udder, the hands of the milker soiled with the saliva may contaminate the milk. In the classical treatise on rabies (Traité de la rage, 1912, page 270), Babes lists the experiments of Nocard, who found that one of four specimens of milk collected from a rabid dog produced typical rabies when inoculated into a rabbit. On the other hand, Roux made the significant observation that he transmitted rabies to the experimental animals only on one occasion, when he mixed the milk of an infected rabbit with a fragment of the mammary gland, while the secretion gently collected from the organ was noninfectious. Bardach (Ann. de l'Inst. Pasteur, 1887, page 180) proved the presence of the virus in the milk of a woman suffering from rabies both before and after death by testing the secretion on rabbits and guinea pigs. The nursling of this woman consumed this milk until the last day before death of the mother without showing any detrimental effects. These positive findings are contrasted by the extensive experiments of Nicolas (Jour. méd. vétérinare et de Zoölogie, Dec. 31, 1905, page 721), who tested the milk of rabid herbivores, and experimented with animals having received highly infectious material intravenously. Since the milk failed to become infectious, he concluded that the rabies virus is not passed into the mammary secretion from the blood. No rabies virus was detected in the lacteal fluid of a rabid sheep in the careful studies described by Repetto (Riforma med., Dec. 14, 1907). More recent studies have yielded essentially the same results. Mugrage (Jour. Lab. and Clin. Med., 1920–1930, 15, page 460) observed a puppy which had fed on a rabid bitch. The animal developed normally. In experiments on rabbits, he was unable to demonstrate any virus in the milk of the diseased rodents. Probably the most convincing series of tests were conducted by Remlinger and Bailly (Compt. rend. Soc. de biol., 1932, 110, page 239 and Ann. de l'Inst. Pasteur, 1932, 40, page 730), who tested the milk of seven rabid guinea pigs, four cats and one dog. In thirty-nine inoculations of milk, only one sample removed from a moribund guinea pig proved infectious. One specimen of mammary gland removed from a dead guinea pig carried the virus. The latter result was anticipated, since the peripheral nerve tissues are known to be the conductors of the rabies virus. Mechanical injuries leading to tears in the glandular structures of the udder may encourage admixtures of the virus to the milk. From the experimental studies one must conclude that *the milk of rabid animals contains the virus only under exceptional conditions.*

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* From the George Williams Hooper Foundation, University of California, San Francisco.

More Recent Observations.

A study of the literature presents no data to prove the presence of the rabies virus in cows' milk. The majority of recent investigators are convinced that, as a rule, a number of additional factors contribute to the protection of the public from consuming infected milk. At a time when the secretion may under exceptional circumstances carry the virus, although it has never been proven for cattle, usually the milk flow has dropped off tremendously; the symptoms of rabies are sufficiently definite to warn the dairyman that the cow is sick and the milk probably harmful. Pasteurization promptly destroys the virus. However, there is always the possibility that the accidental contamination of the milk with the saliva of the rabid animal or other extraneous sources may render the food product infectious. If, on inquiry, the statements of the milker remotely suggest such a possibility, one is confronted with another question: Does the rabies virus pass through the intact mucous membrane of the buccal cavity and the intestinal tract? Experimental studies, which date back to the early studies on rabies, leave little doubt that the intestinal canal is not a suitable portal of entry for the rabies virus. Feeding experiments by Hertwig, Delafond, Renauld and, in particular, Nocard were uniformally unsuccessful. That the intact mucous membrane is not permeable was well illustrated by a critical experiment of Nocard (Les maladies microbiennies des animaux, Paris, 1903, 2, page 465). He fed a fox the highly infectious brain material from six foxes and several dogs which had succumbed to rabies. The animal remained well. On the other hand, Galtier succeeded in four instances of thirty attempts to infect rabbits in which the mucous membrane of the buccal cavity had been rubbed with highly infectious brain material. In the light of the present-day views on the pathways of infection, it is obvious that the accidental exposure of a nerve ending by trauma (rubbing of mucous membrane) may create a suitable portal of entry for the virus. The intact mucous membrane may thus permit the passage of the rabies virus. Superficial defects on the mucosa of the mouth and gums, or fissures and cuts on the lips, tongue or upper digestive tract could possibly serve as such avenues of infection. Disturbances in the gastrointestinal tube or inadequate gastric secretion which ordinarily destroys the virus (0.01 per cent hydrochloric acid at 37 degrees centigrade in two hours) may reduce or entirely inhibit the protection against rabies by ingestion. Despite these arguments for a possible gastroinestinal entry of the virus, there must be recorded convincing epidemiologic evidence against this probability. The meat of emergency-slaughtered animals, rabid cattle and hogs has been eaten by large groups of people without any consequences. Even the cadavers of rabid dogs have not escaped this fate. In not one instance have harmful effects been noted (Joseph Koch).

To Summarize.

In conclusion, it may be stated that the scientific data do not seem to justify the antirabic treatment for individuals who have ingested the clean raw milk from a rabid cow. On the other hand, if contamination of the milk with saliva is within the realm of probability, and the milk has not been pasteurized, the physician should weigh carefully the institution of Pasteurian treatment.

CALIFORNIA MEDICAL ASSOCIATION

This department contains official notices, reports of county society proceedings and other information having to do with the State Association and its component county societies. The copy for the department is submitted by the State Association Secretary, to whom communications for this department should be sent. Rosters of State Association officers and committees and of component county societies and affiliated organizations, are printed in the front advertising section on pages 2, 4 and 6.

CALIFORNIA MEDICAL ASSOCIATION

WILLIAM W. ROBLEE..........President
CHARLES A. DUKES..........President-Elect
LOWELL S. GOIN..........Speaker
KARL L. SCHAUPP..........Council Chairman
GEORGE H. KRESS..........Secretary-Treasurer

OFFICIAL BUSINESS

ASSOCIATION ACTIVITIES

1. *Address of President W. W. Roblee to House of Delegates at Special Session in Los Angeles, December 16 to 17, 1938.*
2. *Report of the Council to the House of Delegates, on Medical Service Plans.*
3. *Enabling Resolutions of the House of Delegates.*
4. *Minutes of the Two Hundred and Sixty-Ninth Meeting of the Council.*
5. *Press Items Concerning the Special Session of the House of Delegates.*

DEPARTMENT OF PUBLIC RELATIONS

1. *Southern California Itinerary of President-Elect Charles A. Dukes and Association Secretary George H. Kress.*
2. *Medical and Scientific Exhibits at the Golden Gate International Exposition.*
3. *State Registration Fee Due from Physicians on January 1, 1939.*
4. *Radio Script on California Humane Pound Act.*
5. *Request for Plans of Physicians' Offices.*
6. *Report on Pacific States Medical Executives' Conference.*
7. *Cancer Exhibit at the Golden Gate Fair.*

ADDRESS OF PRESIDENT W. W. ROBLEE

AT THE SPECIAL SESSION OF THE HOUSE OF DELEGATES HELD IN LOS ANGELES, DECEMBER 17–18, 1938

Mr. Speaker and Members of the House of Delegates of the California Medical Association:

I extend to you greetings from your elected officers and the Council. You may rest assured that you would not have been put to the inconvenience, and the Association to the expense, of this special meeting if we had not felt that the gravity and urgency of the issues involved made it necessary.

This is the second time in the history of the Association that such a session has been called. In both instances the apparent urgency for the Association to consider the problems connected with sickness insurance was the motivating influence.

WHY WAS THE SPECIAL SESSION CALLED?

The question has been raised by some of our members, "Why the haste? Is the Council trying to put something over on us without giving the members an opportunity to consider the problem with full knowledge and deliberation?" You are entitled to an answer to that question.

Your Association is rendering the individual doctor many and varied services. In addition to the work done at the central office, by your officers and by the Council, there are seventeen standing committees and several special committees which have oversight of Association activities during the interval between annual sessions. Four of these committees have had oversight of various phases of this problem. The sickness insurance problem has been actively before us for many years. The report of the Wilbur Committee on the Cost of Medical Care focused our attention on this subject. Many of you remember the hectic session at Riverside when a plan proposed by the Council was rejected, and in its stead the Committee of Five was created and our own "California Medical Economic Survey" ordered.

That was in many respects a sad and very expensive experience. We did, however, learn some valuable lessons, notably that where any money is involved no bill can pass the Legislature that does not give the politicians control, and that a survey directed by a lay economist is bound to be factually faulty and the conclusions misleading.

Following this experience the agitation within our own ranks for some radical and all comprehensive compulsory action became quiescent in the state. Unfortunately, this happy condition did not obtain elsewhere. Because of present and prospective economic uncertainty on the part of many of our citizens a ready field was at hand for the planting and propagation of many bizarre and curious economic plans. These seemed to center about the problem connected with the aged and the sick. These elements in our population have a universal appeal and were pushed as the "guinea pigs" for mass socialized experimentation.

MOTIVATING FACTORS IN SOCIALIZED MEDICINE

The factors which have brought the problem of socialized medicine before us acutely at this time are:

1. *The Attitude and Activities of the Federal Government:*

The report of the Interdepartmental Committee to coördinate health and welfare activities under the chairmanship of Josephine Roche, with its sweeping recommendations, following as it did the very radical statement by Senator Lewis to the Atlantic City session of the American Medical Association House of Delegates, focussed our attention on the imminence of socialized medicine under federal control. A call was immediately issued for a special session of the American Medical Association House of Delegates, this being only the third time in the history of the Association that such a call had been issued. The attitude of organized medicine was clearly set forth and a committee was appointed to confer with the federal group. This conference was held October 30, 1938. The results were not particularly encouraging. In a joint interview following the conference by Dr. Irvin Abell and Miss Josephine Roche reported in the November 18 *Journal of the American Medical Association* "it was pointed out that the conference had reached no definite conclusions or specific plans for coöperation, nor had there been any abandonment of specific position taken by either group in relationship to the program." Doctor Abel further stated "while tentative agreement in principle, not in methods of application, was reached on four of the recommendations, the conference was stymied by the question of compulsory sickness insurance."

It is, therefore, quite evident that the Interdepartmental Committee will sponsor in Congress, with the approval of the federal officials, measures that, if enacted into law, will make profound and, we fear, detrimental changes in the care of the sick citizen.

The fact that the program is one of subsidy whereby states and local units are obliged to match the federal funds, is a possible way out. If California can be shown that the sickness insurance problem is in process of satisfactory solution here it may serve as a block to the undesirable features of the proposed federal program.

2. *The California State Election of November 8, 1938:*

An election occurred in this state November 8. The result was a political overturn whereby the executive and the assembly portion of the legislative branches of our state government passed into the hands of the Democratic party. Judging from past experience with, and the preëlection statements of, the party leaders, we can expect state medicine to be sympathetically considered, if not actually pushed as a part of the state "New Deal" program. The Legislature meets in January, the voting begins in March, and we, therefore, have only a two and a half months' period in which to inaugurate a program of our own which will in a measure satisfy the radical demands and yet be able to keep the program under our control.

It may interest you to know that on this last Wednesday evening occurred the annual legislative dinner of the Public Health League of California. Various legislators were present. Governor-Elect Olson was en route to Washington, but sent his secretary. The secretary, in substance, spoke as follows:

"I don't want to say very much, but I do want to say a few words about medical insurance. I assume that you gentlemen are prepared to accept your responsibilities and do your duty in this regard, but if you are not we will be obliged to present a program of medical insurance to the Legislature."

3. *Farm Bureau Studies:*

Economic conditions confronting our great agricultural population have been very trying for the past several years. Many of our usually solvent, independent farmers have had great difficulty in securing sufficient return from their crops to remain solvent. The dread of the unusual expense entailed by catastrophic illness hangs heavily over them. Your Council and special committees have had three conferences with the State Farm Bureau leaders. They are a splendid group of citizens and we were able to acquire a knowledge of our mutual problems that will be invaluable.

They desire an insurance program and a moderate liberalization of admissions to the county hospitals. They frankly say that unless we present a helpful program they will consider a connection with a private insurance group and join with those who advocate county hospital admission on as free a basis as are the public schools for the education of their children.

The resolution adopted by the Farm Bureau at the state convention at Sacramento in November reads as follows:

Hospitalization and Health Insurance

"*Resolved,* That we oppose any attempt to limit the use of county hospitals by persons able to pay in part or in whole for the service received; that we sponsor or support the enactment of a law establishing a practical basis upon which licensed practitioners may practice group medicine such as voluntary health insurance and other health legislation which will be beneficial to the farm families and that we continue our study of the rural health problem."

4. *Organized Labor:*

The representatives of organized labor have recently stated to one of our officers that they are expecting us to offer a group program that will be within reach of their members.

He has an appointment with the labor representatives next week to advise them as to what can be our response to their request.

5. *Hospital Associations:*

The existing hospital insurance associations have informed us that there is an insistent demand from their clientele that medical care be included in their coverage. Some rather large groups have left them and have secured the double protection from commercial insurance organizations. They have apparently reached the limit of development as hospital insurance carriers.

6. *The Development of Commercial Insurance Carriers:*

A number of insurance companies, for example, the Occidental Life Insurance Company, Giannini controlled, have met the requirements of the Insurance Commission and are writing indemnity policies which give free choice of physician and hospital. The unsatisfactory feature of these policies is that they indemnify under a fee schedule that is materially below a reasonable professional charge and the attending physician has difficulty in explaining the discrepancy and collecting the difference.

7. *Partnership Groups:*

For example, the Ross Loos Clinic in Los Angeles are serving many thousands of clients in this state.

8. *Corporation Requests for Service for Employees:*

Several corporations and business firms have requested us to furnish medical service on a prepayment basis for their employees, and are awaiting the outcome of our deliberation. If organized medicine does not offer such a service they will seek it elsewhere.

9. *Reaction of the General Public:*

Since the publicity that was given the November 12 Council meeting I have received letters from a goodly number of people inquiring as to how soon the service will be available. I have spoken to some service clubs and they expressed a keen interest in it. The Commonwealth Club has a committee studying the subject and they have announced that they will sponsor a bill in the next Legislature.

10. *Attitude of Physicians:*

I have visited and spoken to many county medical societies during the past month, and have found our members keenly interested in this subject. More than one member has advocated our financing and operating a prepayment sickness insurance organization. The San Francisco Society has had the matter under consideration and the Los Angeles Association, with its 2,300 members, has a plan under consideration for possible use in case the California Medical Association fails to work out one of statewide scope.

11. *San Francisco Public Employees Check Off Medical Service Plan:*

The San Francisco County and municipal employees are already organized on a compulsory payroll deduction basis and are out of the picture. We should forestall other similar efforts.

COMMENT

From this summary it appears that federal and state groups, farmers' organizations, organized labor, hospital associations, commercial insurance companies, business and public employees, and our own members all have converged their influence in such a positive manner that it can no longer be ignored by organized medicine. The imminence of the sessions of the National Congress and our own State Legislature furnish additional reasons for earnest consideration of the problem at this time. A policy of laissez faire can no longer be endured. It should also be noted that while we procrastinate the commercial, fraternal and partnership organizations are taking the cream of the business.

The Council does not underestimate the difficulty involved in the development of a plan controlled by the California Medical Association.

Problems of organization, management, finance, salesmanship, coverage, professional control and conduct all hover very large on our horizon. A perfect set-up will not be initially forthcoming. It is possible that they are right who say that voluntary insurance will never solve the problem. The fact remains that it has worked well with many relatively large private groups. Dr. Roscoe L. Leland, Director of the Bureau of Medical Economics of the American Medical Association, informs us that there are some 3,000 plans being sponsored in this country having to do with the problem of medical care. He is here to advise with us.

PLAN WILL BE SUBMITTED BY THE CALIFORNIA MEDICAL ASSOCIATION COUNCIL

The plan that will be laid before you by the Council for your consideration is the result of intensive study on the part of the special committee which was entrusted with its elaboration. The Council spent all day November 12 considering this matter. It called into consultation several men who have expert knowledge along this line of endeavor. The committee has continued its work and the Council spent all day yesterday in further conference in regard to it. It will now pass into the hands of the Reference Committee, and will then run the gauntlet of your judgment. The final product should be reasonably free from error and, we trust, workable.

An earnest endeavor has been made by the Councilors to meet with as many county medical societies as possible in order that the members might become cognizant of the problems involved. Because of lack of a final committee report only a general discussion of the principles involved could be engaged in. The many criticisms and suggestions made have been taken into consideration by the committee and the Council. The Association is a truly democratic organization, but it has a membership of over 6,000, every one a "rugged individualist." It is not to be expected that all the phases of any suggested program will meet with unanimous approval. Good sportsmanship and the welfare of organized medicine will assure a wholehearted acquiescence in the final decision of this body.

This summary of events and the reasons why you have been called into special session I trust will be satisfactory to you.

202 Mission Inn Rotunda, Riverside.

REPORT OF THE COUNCIL TO THE HOUSE OF DELEGATES

Los Angeles, December 16, 1938.

To the Members of the House of Delegates:

As you all have been advised by the formal notice of this special meeting, the Council, at a special meeting held at San Francisco, November 12, 1938, passed the following resolution:

> *Resolved,* That a special meeting and session of the House of Delegates of this Association, California Medical Association, is hereby called to be held at 1925 Wilshire Boulevard, in the city of Los Angeles, State of California, on Saturday, the seventeenth day of December, 1938, at the hour of nine o'clock a. m. for the purpose of:
>
> (*a*) Considering and acting upon any plan or plans presented by the Council for prepayment of, or pooling funds

for, health services and care, and for the establishment of a state-wide system to render medical service and hospital care;

(*b*) Considering and acting upon a proposal to amend Chapter II of the By-Laws of the Association relating to professional ethics; and

(*c*) Considering and acting upon the formation and organization of a corporation and any other matters ancillary or related to any or all of the foregoing purposes as may be presented by the Council; and be it

Further Resolved, That George H. Kress, the Secretary of this Association, be and he is hereby directed to prepare a written notice setting forth the time and place of meeting and the purposes and objects thereof and transmit the same, signed by him and attested by the President, the Chairman of the Council, and the Speaker of the House of Delegates, to each member of the House of Delegates in the manner and within the time required by the Constitution of the Association.

This report to you will be grouped, for the sake of clarity, under five points, as follows:

1. The Council's reasons for calling the meeting.
2. Discussion of the purposes of the meeting.
3. Discussion of possible types of organization based upon the opinions of our General Counsel.
4. Detailed discussion of possible organizations.
5. Recommendations of the Council.

* * *

1. **The Council's Reasons for Calling the Meeting.**—In the past few months the members of the Council have become thoroughly convinced that the membership of the Association generally, throughout the state, desires to put into active operation a state-wide system for the prepayment of medical services and hospital care through the pooling of funds therefor. Committees have been active in Los Angeles, San Francisco, Alameda, and other counties, and it was the opinion of the Council that the membership of the Association, generally, wanted action on this subject, after many years of study, discussion, and surveys. That the public desires it is evidenced in numerous ways—the growth of so-called "hospital associations," private staffs, activities of employers on behalf of their employees, group action by employees, such as the city employees of San Francisco, the demand of policyholders of nonprofit hospital associations for the addition of medical service, the platform plank of our dominant political party in this state, the unanimous endorsement of such a system by the Farm organizations, and the State Federation of Labor, many of whom are now only awaiting the action we take at this meeting to determine their own course, and the widespread approval and satisfaction with which the announcement of this meeting and its purposes has received throughout the state.

The Council felt that the safest and most successful organization could be worked out by the doctors of the state as a whole and not by the doctors of any particular locality. They further felt that it was necessary that the medical profession evolve, formulate, and control any plan for the establishment of such a service and that, in the interests of the proposed beneficiaries and for the preservation of their own standards, unity of professional leadership through their State Association was and is a fundamental requisite.

2. **The Purposes of This Meeting.**—Succinctly stated, these purposes are first to consider and then to act upon the proposals contained in the notice of the meeting. The undertaking is a large one and it would be futile to attempt it unless the profession of the state thoroughly understands the problems involved in the formation of the necessary organization. The Council's committee, consisting of President-Elect Charles A. Dukes, Lowell S. Goin, and T. Henshaw, Kelly, has presented to the Council its report to which is appended the opinions and memoranda prepared by Hartley F. Peart, Esq., the General Counsel. These reports and opinions and the work of the Committee were reviewed by the Council at a special meeting held yesterday, and the Council believes that every question of major importance dealing with the subject has received careful and full attention. These reports will be presented to you in full for your consideration. The Council believes that the report of the Committee and the opinions of our General Counsel show that this Association can authorize the formation of a proper organization to provide medical and hospital service on a prepayment basis, and, at the same time, preserve all the necessary and indispensable safeguards for the protection of the patient and his doctor. In its progress report to the members of the House of Delegates and to the presidents and secretaries of the component county societies, dated November 26, 1938, the Council's Committee sets forth thirteen points, which are as follows:

1. Creation of a medical service organization to operate on a *nonprofit* basis.

2. All doctors of medicine in the state to be eligible to render services under the plan without special privilege to or discrimination against any individual or group of individuals.

3. Complete freedom of choice to the beneficiaries of the plan in the selection of a doctor of medicine who is willing to render services under the plan.

4. Prepayment of the cost of medical services and hospital care on a monthly budgeting basis, all funds collected to be used for defraying cost of medical services, hospital care, administrative overhead, and the building up of a reasonable reserve for contingencies such as epidemics, etc. Administrative overhead to be maintained at the lowest possible figure, consistent with efficient operation and normal growth.

5. Control of administration and policy of the plan to be vested in the medical profession through its representatives.

6. Restriction of hospital care to matters included in the statutory definition of hospital service, viz., "maintenance and care in hospital, nursing care, drugs, medicines, physiotherapy, transportation, material appliances and their upkeep."

7. Medical services to be paid for out of available pooled funds on the "unit system." The unit system has been determined upon because no other method will insure against insolvency or bankruptcy, and because it is evidence to the public of the good faith of the medical profession in the developmental period of this plan.

8. Beneficiary membership in the plan to be open to all falling within the restricted income groups, as rapidly as arrangements can be made therefor.

9. The scope of medical service is contemplated to include everything except industrial injuries, accidents or illness arising from lawlessness, insanity, chronic alcoholism, and drug addiction. Restrictions necessarily must be placed upon cases of pulmonary tuberculosis, pregnancy, miscarriage, and childbirth.

10. The administration of the plan shall be in charge of a board of trustees selected by representatives of the California Medical Association.

11. A medical director, with necessary assistants, responsible to the board of trustees and employed to serve at its pleasure, shall administer the plan and perform the duties usually performed by a medical director where beneficiaries' funds are pooled. Thé medical director shall be a doctor of medicine, not engaged in private practice.

12. District administration will be developed.

13. The board of trustees to have power to establish rules and regulations governing the administration of the plan.

If, after due consideration and full discussion, the House of Delegates believes that the plan recommended will be for the benefit of the patient, the public and the physician, the proper authorizing resolutions directing the Council to proceed should be adopted.

3. **The Two Possible Forms of Organization Reported by the Committee Based Upon Legal Opinions.** On this point it may first be said that up until recently the opinion was current that such a plan as here proposed would require enabling legislation. Recent decisions, however, which show the judicial trend, have led our attorneys to conclude that two types of organization are possible without legislation, with more than favorable chances of their being sustained on judicial review. Suggestions of operating in any unincorporated form, such as a partnership, a trusteeship or an association, are rejected by our legal department for the reasons set forth in an opinion rendered the Committee.

It has also been suggested that the Association could enter into an agreement with a group of insurance companies or a single insurance company and thereby disassociate itself from the handling of funds or engaging to the extent necessary in the administrative work involved. The Council disapproves such suggestion for the reason, first, that to enter into such an agreement inevitably subjects the medical profession to the domination of business capital and, second, that it is not consonant with the purposes desired and would be an attempt to ally a progressive, social and benevolent project with a group of shareholders operating a business for profit. The fundamental idea upon which the Council is proceeding is that the medical service to be rendered shall at all times operate on a nonprofit basis and that the recipients of the service and the physicians and others rendering service, shall be the only parties to the plan.

4. **Two Types of Medical Service Organization Are Possible.**—Our Legal Counsel reports that two types of organization are possible, namely, (*a*) a nonprofit membership medical service corporation, and (b) a nonprofit mutual membership insurance company. The advantages and disadvantages of these two types of organization are summarized in the opinions of the Legal Counsel to the Council Committee.

It appears to the Council that the nonprofit membership medical service type of corporation is by far the more desirable and, while there is no decision of the courts in California directly upon this subject, we direct your particular attention to the quotation given in the Legal Counsel's opinion from the decision in the case of *People* vs. *Pacific Health Corporation*, and to the decision rendered by the United States District Court in the District of Columbia, decided only last July, and covering the two most important points at issue.

The Council believes that the public support of a carefully organized nonprofit membership medical service corporation by this Association, operated prudently and carefully, would be the fulfillment of a public demand of the greatest benefit to the public of the state and that, with some necessary adjustment of thought and action, it would be of direct benefit to physicians themselves.

It will be noted that each of the corporate types presented preserves the essential fundamentals. The projected bylaws contain several matters to which the Council wishes to direct your particular attention: (1) that all doctors of medicine in the state are eligible to render services; (2) the beneficiaries have complete freedom of choice; (3) that the control of the administration and policy is to be vested in the medical profession through the Council of the California Medical Association; (4) the medical services are to be paid out of available pooled funds on a unit system. Some criticism has been voiced on this provision, but it should be borne in mind that such a system affords freedom of action, insures the success of the plan and if dues are not placed at a proper figure they can be rectified at any time. The situation is entirely different from that where the doctors agree to work on a unit system with dues fixed by an intervening agency over which the doctors have *no control*.

District Administration.—So far as possible district administration will be put on an autonomous basis. In the discussion the Council suggests that discussion here should be centered upon fundamentals and not upon details. It will be impossible to work out or decide the many details in the inauguration of a state-wide plan such as this in the deliberations of this body. The type of plan that the profession desires, and its fundamental tenets we respectfully suggest should form the topics of your deliberations. Details must be entrusted to representatives from various geographical areas and differing conditions of medical practice.

5. **Recommendations of the Council.** — The Council, therefore, recommends that this House of Delegates instruct it to take the necessary actions to create and put into operation an organization of the form of, and containing all of the essential provisions embodied in, the tentative drafts of articles of incorporation, by-laws, etc., for the nonprofit membership corporation submitted as part of this report.

Respectfully submitted,
The Council of the California Medical Association.
Karl L. Schaupp, *Chairman.*
George H. Kress, *Secretary.*

ENABLING RESOLUTIONS FOR THE MEDICAL SERVICE PLANS OF THE CALIFORNIA MEDICAL ASSOCIATION

These resolutions, with legends A, B, and C, for reference convenience, appear in the minutes of the Council, under Item 14. (See page 40, second column.)

The resolutions were adopted by the House of Delegates. As stated in the editorial comment, the report of the proceedings of the House of Delegates will appear in the February issue of California and Western Medicine.

COUNCIL OF THE CALIFORNIA MEDICAL ASSOCIATION

Minutes of the Two Hundred and Sixty-Ninth Meeting of the Council of the California Medical Association

Meeting was held in the Auditorium of the Los Angeles County Medical Association, 1925 Wilshire Boulevard, Los Angeles, at 9:45 a. m., Friday, December 16, 1938.

1. **Call to Order.**—The meeting was called to order by Chairman Schaupp, with the following members present: President William W. Roblee, President-Elect Charles A. Dukes, Past-President Howard Morrow, Speaker Lowell S. Goin, Chairman of Council Karl L. Schaupp; Councilors Calvert L. Emmons, Louis A. Packard, Axcel Anderson, Alfred L. Phillips, Oliver D. Hamlin, P. K. Gilman, F. N. Scatena, Henry S. Rogers, Junius B. Harris, W. H. Kiger; Chairman of Public Relations Committee George G. Reinle, Secretary-Editor George H. Kress, General Counsel Hartley F. Peart and his associate, Mr. Howard Hassard.

Absent: C. O. Tanner, abroad; Carl R. Howson, illness; T. Henshaw Kelly; and Harry H. Wilson, illness.

2. **Minutes.**—The minutes of the two hundred and sixty-eighth meeting of the Council were presented and on motion of Charles Dukes, seconded by Howard Morrow, were approved.

3. **Illness of Doctors Howson and Wilson.** — The Secretary reported on the illnesses of Doctors Howson and Wilson.

It was moved by Axcel Anderson, seconded by J. B. Harris, that the Secretary extend to Doctors Howson and Wilson the sympathy of the Council. Carried.

4. **Loan to Association.**—The Secretary reported that in order to meet the current expenses of the Association,

incident to the special session of the House of Delegates and other needs, it had been necessary to borrow from the Trustees Of The California Medical Association an additional $5,000. It was stated that it was necessary that the action taken by the officers of the Trustees Of The California Medical Association in making, executing, and delivering a promissory note dated December 13, 1938, to the bank lending the additional $5,000 receive the approval of the Board of Directors of the Trustees Of The California Medical Association.

5. **Recess of Council.**—At this point a recess of the Council was declared to permit a meeting of the Trustees Of The California Medical Association.

6. **Call to Order.**—After the recess Chairman Schaupp called the meeting of the Council to order.

7. **Loan.**—Concerning the report of the emergency loan, previously discussed, on motion of George Reinle, seconded by Axcel Anderson, the action of the Chairman of the Council, the Chairman of the Auditing Committee and the Association Secretary-Treasurer, in arranging an additional loan of $5,000 from the Trustees Of The California Medical Association, was approved; and authority was given to borrow an additional $5,000 from the Trustees Of The California Medical Association, should necessity arise therefor. It was agreed that these loans from the Trustees should be repaid early in 1939, after the dues for the next year had been received.

8. **Publicity Committee.**—The desirability of appointing a committee to handle publicity was discussed. The names of various publicity men were presented.

It was moved by Charles A. Dukes, seconded by A. E. Anderson, that a special committee be appointed to handle publicity under instructions from the President of the Association. Carried.

It was agreed that the Special Committee on Medical Service Plans (Doctors Dukes, Kelly, and Goin) should act in such capacity.

Doctor Harris voted in the negative.

9. **Retired Membership.**—The Alameda County Medical Association having recommended for retired membership Dr. H. J. Kohlmoos, who had retired from practice, it was moved by Charles A. Dukes, seconded by William W. Roblee, that H. J. Kohlmoos be granted retired membership in the California Medical Association. Carried.

10. **Clarence G. Toland.**—It was moved by President Roblee, seconded by F. N. Scatena, that the courtesy of attendance at the Council meeting be extended to Clarence G. Toland, former president. Carried.

11. **Medical Service Plan.**—At this point, at the request of President Roblee, Council Chairman Schaupp stated that the Council would now pass on those items on the business docket pertaining to the proposed medical service plan.

Charles A. Dukes, Chairman of the Special Committee on Medical Service Plans, then submitted to the Council the report of the Special Committee's work subsequent to the last Council meeting held on November 12, 1938, and, in addition, submitted to the Council drafts of seventeen documents comprising two progress reports to the members of the House of Delegates dated November 26, 1938, and December 12, 1938, respectively, a preliminary and a final report of the Legal Counsel discussing in detail the legal problems connected with a medical service plan, four formal written opinions of the Legal Counsel covering the major legal questions involved, and articles of incorporation, by-laws, rules and regulations and membership certificates of two alternative types of organization, namely, nonprofit membership medical service corporation, and mutual chapter 9 insurance corporation.

Each of the documents submitted by the Special Committee on Medical Service Plans was then read in full to the Council and careful consideration and discussion was had concerning a number of the principles and points presented in the Committee's reports and in the reports, opinions and drafts of documents presented by the Legal Counsel. Mr. Peart and Mr. Hassard discussed each of the legal questions presented in their reports and written opinions, and Charles A. Dukes and Lowell S. Goin, on behalf of the Special Committee, presented and discussed the various considerations which have led the Committee to the conclusions contained in its report to the Council.

12. **Recess.**—At this point a recess of the Council was declared for luncheon.

13. **Delegates' Expenses.**—Discussion was had of the payment of expenses of delegates attending the special session of the House of Delegates.

In accordance with past procedure, the payment of round-trip railroad fare and lower berth for each delegate was approved.

It was moved by Charles A. Dukes, seconded by Lowell S. Goin, that delegates attending the special session of the House of Delegates be allowed a per diem of $5 for the two-day session. Carried.

14. **Medical Service Plan.**—At this point consideration was given to the Special Committee's report on tentative drafts of the Articles of Incorporation; By-Laws, and Rules and Regulations for a medical service plan.

The Secretary asked for instructions on distribution of the report of the Council to the House of Delegates.

On motion of Howard Morrow, seconded by F. N. Scatena, the report was ordered mimeographed in sufficient number for distribution to the members of the House of Delegates.

The Special Committee on Medical Service Plans and the Legal Counsel then presented to the Council a preliminary draft of a proposed report from the Council to the House of Delegates. The preliminary draft was read to the Council and then revised in certain particulars suggested by the councilors present.

It was moved by Lowell S. Goin, seconded by George Reinle, that the report of the Council as submitted by the Special Committee and as revised, be presented to the House of Delegates as the Council's report. Carried.

The following resolutions were then presented for the consideration of the Council:

Resolution A

Resolved, That the House of Delegates of the California Medical Association, in special session assembled at Los Angeles, California, this seventeenth day of December, 1938, favors the formation of an organization for the prepayment of or pooling funds for health service and care and for the establishment of a state-wide system of medical service and hospital care.

Resolution B

Resolved, That the House of Delegates of the California Medical Association, in special session assembled at Los Angeles, California, this seventeenth day of December, 1938, exercising its powers under the constitution of this Association—California Medical Association—does hereby authorize, direct and empower the Council of this Association forthwith to cause to be created, fully organized and embarked upon its activities, a California nonprofit corporation which shall have power to undertake a state-wide voluntary medical service plan and shall, in fundamental principles, conform to the proposed plan submitted to the House of Delegates by the Council at this special session.

Resolution C

Resolved, That the House of Delegates of the California Medical Association, in special session assembled at Los Angeles, California, this seventeenth day of December, 1938, hereby authorizes, empowers and directs the Council of this Association—California Medical Association—to lend or advance, upon such terms as it deems desirable, to any nonprofit medical service corporation caused to be formed by it, such sum or sums from the funds of the Association up to a maximum of $15,000 as it deems necessary or expedient; and be it

Further Resolved, That the Council is hereby requested to approve this resolution as required by Section 1 of Article XI of the Constitution of this Association.

It was moved by William W. Roblee, seconded by J. B. Harris, that the three foregoing resolutions be presented to the House of Delegates. Carried.

15. **Order of Business.**—After discussion it was agreed that the House of Delegates would convene at 9:30 a. m. on Saturday, December 17, 1938, with suggested order of business somewhat as follows:

Report of the Credentials Committee; Announcement of the Reference Committees; Address of the President; Explanation of the social and economic and political desirability of a medical service plan by Doctors Kelly and Harris; Report of Council; Recess for luncheon; Reconvening at 2 p. m. The House then to resolve itself into a Committee of a Whole for consideration of medical service plans; with hearing of the reports of the Reference Committees, and formal voting to take place after such consideration, on Sunday, December 18.

16. **Principles of Medical Ethics.**—President William W. Roblee presented a proposed amendment to the by-laws dealing with the principles of medical ethics. The proposed amendment would govern the solicitation of beneficiary members by any nonprofit organization defraying the cost of medical service under a plan approved by the California Medical Association, or any constituent county society.

It was moved by William Roblee, seconded by J. B. Harris, that the amendment to the Principles of Medical Ethics be submitted to the House of Delegates. Carried.

17. **Reference Committees.**—Speaker Goin stated that he had named as members of the Reference Committees the following:

Reference Committee No. 1

(For Consideration of Medical Service Plans)

P. K. Gilman, Chairman, San Francisco; S. J. McClendon, San Diego; F. R. Makinson, Oakland.

Advisory members: John C. Ruddock, Los Angeles; Roy A. Terry, Long Beach.

Reference Committee No. 2

(For Consideration of Matters Ancillary to Medical Service Plans)

C. Kelly Canelo, Chairman, San Jose; Bon Adams, Riverside; F. A. MacDonald, Sacramento.

Advisory members: G. W. Walker, Fresno; Gertrude Moore, Oakland.

Credentials Committee

T. D. Caruso, Los Angeles, Chairman; Mast Wolfsohn, Monterey; Dexter Ball, Orange.

18. **Recess.**—At this point the Council recessed to meet at the call of the Chairman.

19. **Call to Order.**—The meeting was called to order in the Barlow Medical Library of the Los Angeles County Medical Association, Los Angeles, California, Saturday, December 17, at 5 p. m., with the following members present: President Roblee, President-Elect Dukes; Councilors Schaupp, Emmons, Goin, Packard, Anderson, Phillips, Hamlin, Scatena, Harris, Rogers, Kiger, and Kelly; Chairman of Public Relations Committee Reinle, Secretary-Treasurer-Editor George H. Kress. R. G. Leland of Chicago, by invitation.

Absent: Doctors Gilman, attending Reference Committee meeting; C. O. Tanner, abroad; Carl R. Howson, illness; Harry H. Wilson, illness. Mr. Peart and Hassard attending Reference Committee meetings.

20. **Membership.**—The Association Secretary presented a letter from a County Society concerning one of its members whose license had been revoked by the Board of Medical Examiners of the State of California. The advice of the Legal Counsel was ordered to be followed.

21. **Residency Requirement.**—In discussion of the residency requirement for physicians who applied for membership in the California Medical Association on the basis of transfers from other state associations, it was the consensus of opinion that the six months' residency requirement as provided in the by-laws, before membership was granted, must be observed by component county societies.

22. **Social Security.**—The Secretary reported that a mandatory payment of $57.88 had been made to the collector of Internal Revenue on the Federal Social Security Act, and stated that one-half the amount or $28.94 should be collected from employees. The Secretary was instructed to collect the proper pro rata from each employee.

23. **Nursing Practice Act.**—Discussion was had of the proposed bill to establish a separate examining board for nurses, who now receive their licensure certificates from the California State Board of Public Health.

It was moved by Lowell S. Goin, seconded by Charles A. Dukes, that discussion of the nurses bill be indefinitely postponed.

In voting there was a division, with 8 ayes and 3 nayes. Doctors Harris, Kelly and Roblee voting in the negative.

24. **Southern California Society for the Control of Syphilis and Gonorrhea.**—The Secretary reported that Mrs. Hafford of the Southern California Society for the Control of Syphilis and Gonorrhea has presented a progress report on the proposed antivenereal legislation. No action taken.

25. **Humane Pound Act.**—The Secretary reported that a letter of appreciation of the activities of the California Society for the Promotion of Medical Research and the Association had been received from Doctor West.

26. **Social Well-Being.**—A letter was read from Joseph Mussatti regarding membership of Doctor Kress on the Republican Committee on Social Well-Being. In accordance with the policy of the Association, the Secretary was instructed to decline the appointment.

27. **Liquors.**—It was the sense of the Council that advertisements for wines and liquors be not solicited by CALIFORNIA AND WESTERN MEDICINE.

28. **Advertising Rates.** — The Council approved the present schedule of advertising rates for special space in the JOURNAL, as outlined by the Secretary.

29. **American Medical Association Survey.**—The Secretary presented a letter from the San Francisco County Medical Society stating that the Society could not undertake the tremendous task of compiling data for the American Medical Association Survey at this time.

30. **Farm Bureau.**—Doctors Rogers and Packard reported on the conference held with the Farm Bureau representatives on November 19. Both Doctors Packard and Rogers spoke of the desirability of another meeting with the Farm Bureau. It was felt that any proposed legislation should be referred to the Legislative Committee.

It was moved by T. Henshaw Kelly, seconded by C. A. Dukes, that the Committee continue its activities and report back to the Council or Executive Committee.

It was the sense of the Council that if further conferences were necessary in the judgment of the Committee, they should be held.

31. **R. G. Leland.**—R. G. Leland, Director of the Bureau of Medical Economics, spoke to the Council on medical service plans and offered the coöperation of the American Medical Association in the problems of the Association.

32. **Adjournment.**—There being no further business the meeting adjourned.

GEORGE H. KRESS, *Secretary.*

Attest:

KARL L. SCHAUPP, *Chairman.*

PRESS ITEMS CONCERNING SPECIAL SESSION OF HOUSE OF DELEGATES AT LOS ANGELES *

Some editorial comments:

The Doctors' Christmas Gift †

The California Medical Association has made the state a worth-while Christmas present through the action of its House of Delegates approving an all-California system of medical insurance. At the same time the doctors probably have done themselves and their profession a service by a step calculated to head off the incursion of "state medicine" in this commonwealth.

Most people, believing that government-financed medical insurance is still in the stage of debate, will be surprised to know that one federal agency has, on its own initiative, established the system in some twenty states. The Farm Security Administration—formerly Rex Tugwell's Resettlement Administration—is now financing as an adjunct to farm aid what amounts to state medicine for more than 100,000 families. In the Dakotas, where the movement has attained its greatest scope, about 77,000 Federal Security Administration clients receive medical, surgical, and dental care, with all necessary hospitalization, on an insurance system for which the Administration pays $2 a month per head. Altogether about three thousand country doctors are enlisted and get 51 per cent of the money, hospitals 37 per cent, dentists 8 and druggists 4, according to an article by Samuel Lubell and Walter Everett in a recent issue of the *Saturday Evening Post.*

The immediate difference between state medicine as so practiced and the medical insurance plan which is being pioneered by the doctors and hospitals in California is that in the former the cost is defrayed in whole or large part by the Government, and in the latter by the individual beneficiaries themselves. Actually, the difference is that between political paternalism on the one hand, and independent self-help on the other. State medicine is another extension of remote-control "relief" under which large groups of voters are made beholden to a centralized government; privately administered medical insurance is the application of actuarial principles to bring within the reach of the most modest private purse heretofore costly medical and hospital care. The one is open to all the political abuses and chiseling which have made Government relief a national scandal; the other, while yet to be tried on a large scale, is at least an intelligent effort to help the poor to help themselves. The first would turn the Hippocratic profession into another tax-financed Government bureau; the second would extend its benefits to everyone without the taint of politics or charity.

The California plan wisely proposes to benefit first those most in need of low-cost care and hospitalization. It is hoped to make these available to the small-income groups at not more than $2.50 per month for individuals and not more than $6 for families, regardless of size. If all the California Medical Association members and all the hospitals which have so far entered insurance groups subscribe to the plan, as is expected, those insured will have their choice of doctors and of hospitals as well. In all, the plan is expected, within three months, to make the services of some six thousand physicians and surgeons and several hundred hospitals available to perhaps one million persons to whom such care has heretofore been wholly or largely unattainable by reason of its cost.

An enormous amount of detail remains to be worked out, but the majority favor which the plan enjoys among the doctors themselves is practical assurance of its successful launching.—Editorial, Los Angeles *Times,* December 20, 1938.

* * *

Health Insurance

Would you pay $2.50 to $2.65 a month, like insurance, in order to have your doctor and hospital bills already taken of when you become ill or must have an operation? You may receive such an offer within a few months from California's medical profession. So you might as well begin thinking about what it means to you, personally, that the California Medical Association's House of Delegates has voted 9 to 1 to establish low-cost health insurance.

Our doctors have taken a great forward step.

Here is to be a voluntary system, making available the services of some of the best physicians, surgeons, and hospitals in the state to the small salary or wage-earner. The goal is to set up reserve funds through monthly payments so that when a major illness strikes it will not take a wage-earner's last cent, run him into debt and prove a harrowing burden. Insured persons will have their choice of the physicians and hospitals joining the plan.

* * *

The California program, if carried out in the purposeful manner promised by the Medical Association, will not be a mere gesture to head off Government socialized medicine or compulsory health insurance controlled by laymen and politicians.

A method of distributing the high cost of illness has been bound to come. Alert doctors see the trend. The profession declares the doctors, not outsiders, should run health services. We hope that the doctors themselves do meet the needs of the people.

Medical men have their biggest tasks ahead in the next few months when they will work out the details and offer the new health insurance to thousands of Californians. They can't just set up the plan and let it go at that. The idea must be sold.

Labor unions, other employees and employers as well should give attention to the plan. They could be of great service to the Medical Association in putting the far-reaching program in operation.—San Francisco *News,* December 20, 1938.

* * *

Medical Care Plan

California, which has traditionally led the nation in many progressive measures, such as the initiative, referendum, recall—to mention only a few—again leads with what may be the beginning of a new health era.

Seven thousand California medical men, through their representatives in convention, overwhelmingly adopted a program of state-wide health insurance.

In an editorial at the time the subject of "state medicine" was being discussed here before the American Medical Association, this newspaper pointed out that the wise measure would be a voluntary step in the direction of care for those in the lower income brackets, rather than wait for national or state legislation.

* * *

And that's why this step of the California medical men is so important: because it was voluntary and a real effort by the doctors themselves to solve the problem.

This problem, simply stated, is merely to insure at low cost for those who have incomes under $2,500 a year (or some comparable figure) an ability to have medical and hospital aid.

Much illness, and much final desperate surgery, can be avoided and the ailment successfully treated easily and rapidly and inexpensively if treated in formative stages.

But in the lower-income brackets, persons themselves ill or having ill dependents often "let it go" in the hope of saving expense—whereas, in fact, the expense may eventually be much greater, often greater than can be borne, in cases where the ailment is not immediately attended to.

* * *

By the physicians' new plan, for a very small sum, indeed, such persons would have a guarantee of the best treatment possible by the doctor of their own choice, as well as hospitalization.

The plan has been worked out carefully, but there are yet details to be polished.

That the plan may work is everyone's ardent wish, both from the point of view of the patient and the physician, as well.—San Francisco *Call-Bulletin,* December 20, 1938.

* * *

Medical Trail Blazing

From what we hear about its recently announced plan, the California Medical Association is going to blaze an entirely new trail in health insurance in the United States.

The meeting in Los Angeles of the Association's House of Delegates not only adopted recommendations of its Special Committee on Health Insurance, thereby paving the way for early beginning of this service throughout the state, but also approved two other steps that are decided innovations.

One is a proposal that the Association create a commission whose function will be to examine private health insurance plans (there are a number operating in the state now) and issue certificates of approval to those that meet certain standards to be set up by the Association. Examination, of course, would be only upon application by any private company. There would be no compulsion, and the commission would have nothing to offer except endorsement of the medical profession and the prestige such endorsement would give. By this means the medical fraternity would avoid implications of monopoly in the health insurance field.

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* Note: The press comments of editorial and other nature which appear in this column, refer to the special session of the California Medical Association House of Delegates, held in Los Angeles, December 17-18, 1938. Their perusal will permit members of the California Medical Association who were not in attendance, to visualize somewhat the immediate reaction of the press representatives who were present, as well as the reaction of editors of newspapers from different sections. In the February issue of CALIFORNIA AND WESTERN MEDICINE it is planned to present more definite information concerning the details of the California Medical Association medical service plans.—K.

† See also cartoons under similar title, from the San Francisco *News,* in this issue, on pages 78 and 79.

* * *

The other new idea, advanced by the Santa Clara County delegation to the House of Delegates and adopted at the convention, is a proposal that the state set up a subsidy plan similar to that of Palo Alto, whereby all permanent residents of the community are allowed $2.50 a day, for a limited time, upon their hospital bills in the Palo Alto Hospital, the money coming from the city treasury. The doctors believe they can show the state and its political subdivisions will save money by such a plan and that ultimately it will do away with the need for county hospitals in all but the larger centers of population, when operated in conjunction with the proposed health insurance plan.

·For instance, they suggest the state might insure all its indigents as a group, thereby guaranteeing adequate medical care and thus effectively safeguarding the public health.

* * *

These ideas are long steps along the road of progress in the realm of coöperative medicine. The *News* for years has advocated that the medical profession itself accept the responsibility of establishing a state-wide health insurance system. That, after many years of delay, it now is undertaking the job is a credit to the Association and, we hope, will prove to be another mark of the progressivism that is typical of California.—San Francisco *News*, December 26, 1938.

What reporters wrote concerning special session:

Doctors Offer Low Cost Hospital-Medical Plan on Pari-Mutuel Basis

Los Angeles, November 18.—(UP).—America's first extensive medical service plan to provide doctor and hospital care at low costs to a majority of wage earners and their families was outlined today by leaders who will submit it to the California Medical Association next month.

Representing six years of study and research, the plan was explained in detail for the first time to two thousand members of the Los Angeles County Medical Association by Dr. Lowell S. Goin, speaker of the California Medical Association's ruling House of Delegates and chairman of the county and state committees in charge of the program.

The plan, anxiously awaited by the American Medical Association, which traditionally has opposed all such theories, provides in effect a "pari-mutuel" system of fees to coöperating physicians and unlimited medical service and limited hospitalization to subscribing families at a maximum cost of $72 a year. The program, if approved December 17 by the House of Delegates, will be binding upon all county medical units in the state. Professional membership is optional, but in the view of leaders, the implied penalty of loss of patients to noncoöperating physicians would make membership virtually mandatory.

Details of Plan

Subject to modification, the plan stacks up as follows:

Eligible to subscribe to the service would be all workers earning under $2,500 a year. Costs would start at $2.65 a month for the individual and increase by $1.00 for each additional dependent up to a maximum of $6.00 for the family, regardless of its size. Dependents would be defined on the same basis that the government defines them for income tax purposes. Patients are free to select their own doctor and hospital.

Subscribers would be guaranteed medical care and hospitalization for all maladies excepting insanity and mental diseases, acute alcoholism, narcotic addiction, and tuberculosis of the kind where sanitarium treatment is required. Broadly speaking, the profession regards these exceptions as cases for state or federal supervision. The service would allow treatment for venereal diseases, but hospitalization for cancer sufferers and those with similar malignant diseases would be restricted to operative and therapeutic treatment.

Hospitalization Limited

In all cases, hospitalization would be limited to three weeks per person per year. The average operative case requires only twelve days. Service privileges would apply at once, except for maternity patients, who must have been subscribers for a year.

Coöperating physicians and surgeons would be paid on a basis of "units," the value of which would be determined quarterly by the Board of Trustees, the administrative body. A tentative schedule suggested as "unit" fees: Five units for complete physical examination, 10 for confinement cases, excluding delivery; 1 for office visits, 20 for appendectomies; 2 for x-rays, etc.

Each doctor would compute his total units and present his bill to the Board of Trustees, which would pay him in cash from the general "pool." The value of the unit would necessarily fluctuate in accordance with the amount of cash left in the pool, after hospital and administrative costs are first deducted. Thus, if $2,000 were left in the pool to redeem 4,000 units, each unit would be worth 50 cents in the same manner that pari-mutuel payoffs are determined.

Plan Still Inperfect

Conceding that the plan is by no means perfect, Doctor Goin emphasized the committee would make no recommendations, leaving the question of adoption entirely up to the general profession. Many of the provisions will be changed and it is possible that a lower rate may be offered lower income groups, he said.

Committee members deny the project is designed to forestall socialized medicine and insist it was undertaken primarily to afford greater health opportunities to the public. Individual physicians, however, profess concern over the possibility of government intervention, objecting chiefly to the risks of dictation and to excessive administration costs. In England, the administrative costs were said to run between 40 and 60 per cent, leaving little for the physician and hospital.—Hanford *Journal*, November 19, 1938.

* * *

State Medical Body Plans for Care and Hospital Service System

With a view to heading off, if possible, socialized medical and hospital care by the state and also of meeting the federal government's move against the so-called medical trust, the council of the California Medical Association is planning a system for adoption and execution by the general association.

It provides for care and hospital service on monthly payments and will be buttressed upon a form of insurance that will make it easy and cheaper for that class of citizens which is not able to stand expensive hospitalization under physician's care. Taking Time by the forelock in such a venture marks an advanced step by the medical profession. It is intended to effectuate greater health in the state at a minimum cost.

The medical association has long anticipated the growing demand of state medicine and hospitalization. Opposition to it not only in California but elsewhere in the nation has not been successful in halting the movements. And since it is apparent such socialization is coming, the medical men here and in other states have been trying to work out a system that will meet the public demands and that will furnish, possibly, a basis for a national plan. Whether this can be done remains to be seen.

The medical association of the state must be given credit for the movement started in good faith. It is in the right direction.—Tulare *Advance-Register*, November 24, 1938.

* * *

California Doctors Map Insurance Plan

Monthly Pay Medical Treatment Favored

San Francisco, November 27—(AP). — First concrete steps toward establishment of medical insurance for all Californians on a monthly payment basis were taken here today when a special committee of the State Medical Association announced principles to be recommended for the project.

The committee, appainted to outline the medical service plan and submit it to the Medical Association's House of Delegates for final action at a Los Angeles meeting December 17, said it had agreed upon the following points:

1. The organization must function on a nonprofit basis.
2. All doctors must be given opportunity to participate.
3. All patients must have complete freedom to choose their doctor and their hospital.
4. The scope of medical service to be offered must be "as broad as possible." — Memphis, Tennessee, *Commercial-Appeal*, November 28, 1938.

* * *

State Medical Plan Is Proof of United States Trend

California Proposal Is Type Opposed by American Medical Association, Urged by Government

Cleveland, November 29.—The action of the California Medical Association in taking under consideration a plan to provide doctor and hospital care through voluntary insurance to workers earning less than $2,500 per year is graphic proof that widespread changes are on their way in the economic side of American medical practice.

Ultraconservative spokesmen of the American Medical Association have blasted away at the plans of the Federal Government to do something about the medical problems of the low-income groups in America. They have maintained existing methods and facilities are adequate.

However, it has been becoming increasingly evident that the rank and file of medical men in America did not agree.

The action of the California medicos is the most spectacular demonstration of that fact.

American Medical Association Battles Plan

By voluntary action, the California plan would bring about exactly the kind of situation against which the American Medical Association leaders have been battling.

Briefly, the plan provides that any worker earning less than $2,500 a year would pay $2.65 per month, entitling him to all medical care needed with the exception of certain conditions already provided for by state institutions, a maximum of twenty-one days hospitalization. Members of his family could be brought under the plan by an additional payment of $1.00 per member or a maximum of $6.00 per month.

Cleveland's Plan

It is interesting to compare this California plan with what is being done elsewhere. The most successful hospitalization plan is now in operation in Cleveland and has 145,000 subscribers.

This provides a maximum hospitalization of three weeks on the following system of payments from an individual cost of 60 cents per month to an entire family cost of $1.90.

The Cleveland Academy of Medicine is now studying a plan which would offer coverage of doctor bills for illnesses requiring hospitalization.

United States Likely to Approve

It seems entirely probable that the Federal Government will welcome the California experiment.

Speaking before the City Club in Cleveland, Dr. Warren F. Draper, executive officer of the United States Public Health Service, emphasized the fact that the Federal Government had no one plan for the entire nation and no desire to force any plan upon the states.

He said it was desirable for each state to work out its own plan so that local conditions might be met and so that the nation might learn by experience the desirable or undesirable features of any given plan.—By David Dietz, Scripps-Howard Science Editor, San Francisco *News*, November 29, 1938.

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California Medical Association Council Gets Health Plan Report

Special to The Chronicle

Los Angeles, December 16.—The Council of the California Medical Association in executive session today completed its report on the controversial issue of health insurance.

Tomorrow the medical group's House of Delegates, acting with final authority of organized medicine, will decide on the new system.

No definite plan for health insurance has yet been set, doctors' spokesmen said.

The California Medical Association Council last month authorized a special committee to gather all available data. This report was presented today by Dr. Charles A. Dukes of Oakland, president-elect of the Association, and chairman of the special committee.

Fees Discussed

Doctor Dukes denied that costs and fees have been scheduled. He said that while the figure of $2.50 per month had been discussed as approximate cost of medical and hospital service, neither this amount nor the plan itself has yet been approved.

Other medical leaders explained that the principle of insuring against costs of illness is supported by numerous doctors, as witnessed by their organized sponsorship and personal membership in nonprofit hospitalization funds, such as the Bay Region's Insurance Association of Approved Hospitals.

In the face of reported San Francisco controversy over the whole issue, Northern doctors said they were in agreement on the basic idea of health insurance and were confident that details could be worked out.

Los Angeles Going Ahead

Executives of the Los Angeles County Medical Society meanwhile let it be known that they are "going ahead with health insurance."

The southern group has already adopted a plan which will be put into effect locally if the state body fails to agree, Los Angeles doctors said.

Saturday's session of the House of Delegates will be presided over by Dr. W. W. Roblee of Riverside.—San Francisco *Chronicle*, December 17, 1938.

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Socialized Medicine Plan Drafted

Los Angeles, December 17—(AP).—Socialized medicine costing $6.00 a month per family, regardless of size, was recommended today to the California Medical Association's House of Delegates by a special committee appointed to study the plan.

The plan as outlined by Dr. C. A. Dukes of Oakland, chairman of the committee, would be under control of the State Medical Association, and administered by a corporation.

Howard S. Hassard of San Francisco told the Board any other plan of administration would mean a partnership involving individual responsibility and possible liability to Federal and State income taxes.

Pooling of Funds

Doctor Dukes' committee reported membership of the Association desires to put into actual operation a system of prepayment medical service and hospital care through the pooling of funds.

While the exact cost was not figured, the committee's estimate was $2.50 for each participant, with the cost lower if 500,000 persons participated.

One suggestion was for a charge of $2.65 monthly per person. This would increase $1.00 monthly for each dependent and allow medical, surgical and hospital treatment in emergencies for a $6.00 monthly fee for an entire family, regardless of its size.

Under the plan the patient would be at liberty to select his physician and hospital.

The committee reported the plan should be worked out by the doctors of California as a whole, rather than by those of any particular locality. It reported that the medical profession should "evolve, formulate and control any plan for the establishment of such service," that it be operated on a nonprofit basis and that all doctors of medicine be eligible to render the service.

Report Quoted

"This Association can authorize the formation of a proper organization to provide medical and hospital service on a prepayment basis and at the same time preserve all the necessary and indispensable safeguards for the protection of the patient and the doctor," said the report.

Doctors would be reimbursed on a "unit basis," all prepayments being pooled and the doctor paid according to the unit scale, grauating from treatment for minor ailments to major operations. The committee disapproved a suggestion that the medical association enter into an agreement with an insurance company to carry out the plan, protesting it "would inevitably subject the profession to the domination of business capital."

Associated with Doctor Dukes in formulating the tentative plan were Dr. T. Henshaw Kelly of San Francisco and Dr. L. S. Goin of Los Angeles.

Warning Sounded

Dr. William W. Roblee of Riverside, president of the California Medical Association, warned that if the Association did not take up the matter of health insurance and evolve a plan "it is likely some methods will be established by legislation."

"If our profession in California can show that sickness insurance can be worked out successfully, it may block undesirable features of legislation expected to be introduced in Congress," he said.

Doctor Roblee said that Governor-elect Culbert Olson had said through a spokesman that it was assumed California doctors were willing to do their part in furnishing medical insurance, but that if they did not, a program for insurance would be submitted for the California Legislature.—San Francisco *Chronicle*, December 18, 1938.

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California Medical Aid Plan Outlined

Clinic Help at Cost Is Proposed

A large-scale plan to furnish medical service at cost, open to all the people of California and under control of the medical profession, was outlined today in a report to the House of Delegates of the California Medical Association by the Council of the Association.

Dr. C. A. Dukes of Oakland, chairman of a special committee, which prepared the report, said that the cost of the service had not been figured out exactly, but it was estimated that it would be around $2.50 a month per person. This would depend largely on how many persons took advantage of the service, he said.

May Get Family Rate

If as many as half a million persons become beneficiaries, he said, a lower rate could be established for families.

One suggestion was that a rate of $2.65 a month per person be established, increasing $1.00 for each dependent to a maximum of $6.00 per month for a family, regardless of size.

Beneficiaries under the plan would be entitled to complete medical, surgical and hospital treatment in case of necessity. They would be at liberty to select any doctor they preferred and, also, to select any hospital, if space were available in such hospitals.

Tax Problem

Doctor Dukes said that it was recommended that a corporation be formed to administer the plan, and Howard S. Hassard of San Francisco, attorney for the Association, said that any other plan of administration would mean a partnership involving individual responsibility. Hassard said that if the plan is successful it would mean a collection of millions of dollars annually and these receipts, under a partnership administration, might be held liable to federal and state income taxes.

Doctor Dukes said the question had also been raised as to whether the organization would be subject to the state insurance laws and to the registrations of the state insurance commissioner. Hassard said there was no court decision in California establishing a precedent in this connection.

Doctor Dukes said that the choice seemed to be between incorporating as a mutual insurance company, subject to the insurance commissioner, or incorporating as a nonprofit company under the jurisdiction of the state corporation commissioner.

About 150 doctors were present at the meeting of the House of Delegates at the County Medical Association Building at 1925 Wilshire Boulevard.

The report stated that the members of the Council "have become thoroughly convinced that the membership of the Association generally throughout the state desires to put into actual operation a state-wide system for the prepayment of medical service and hospital care through the pooling of funds therefor."

It was further stated in the report that the Council feels that the safest and most successful organization could be worked out by the doctors of the state as a whole and not by the doctors of any particular locality.

It was further stated that the Council felt that the medical profession should evolve, formulate and control any plan for the establishment of such a service.

Say Plan Practical

Reports of the Council, it was also stated, "show that this Association can authorize the formation of a proper organization to provide medical and hospital service on a prepayment basis and at the same time preserve all the necessary and indispensable safeguards for the protection of the patient and the doctor."

It was recommended that the service operate on a nonprofit basis, with all doctors of medicine eligible to render service.

The doctors would be reimbursed on a "unit basis." All prepayments would be pooled and when a doctor renders a service he would be paid according to the number of "units" he had rendered. This was explained as meaning that a treatment for a minor illness would constitute a single unit, with ascending scale of units for more serious illness or operation.

Board of Trustees

It was proposed that a board of trustees be created to put the plan into effect and that a medical director be appointed to administer it. Another proposition was that district administrative centers be developed.

The Council disapproved a suggestion that the medical profession enter into an agreement with a group insurance company or a single company to carry out the plan. The report stated that to enter into such an agreement "inevitably subjects the medical profession to the domination of business capital."

Associated with Doctor Dukes in the preparation of this report were Dr. T. Henshaw Kelly of San Francisco and Dr. L. S. Goin of Los Angeles and a speaker of the House of Delegates.

Dr. William W. Roblee of Riverside, president of the Association, explaining why the matter of health insurance had been taken up, declared that if the Medical Association did not work out a plan it was likely that some methods would be established by legislation.

Other Plans Under Way

"If our profession in California can show that sickness insurance can be successfully worked out it may block undesirable features of legislation expected to be introduced into Congress," he said.

Doctor Roblee also said that a spokesman for Governor-elect Culbert L. Olson had made the statement that it was assumed that the doctors were willing to do their part in furnishing medical insurance, but if they did not, a program for insurance would be submitted for the California Legislature.

"If organized medicine did not render this service to the people they will seek it elsewhere," he said.

He also stated that the Los Angeles County Medical Association has a plan for insurance under consideration which it will propose if the State Association fails to act.

The Council recommended that the House of Delegates instruct it to take necessary action to create and put the proposed plan into operation.—Los Angeles *Evening Herald*, December 17, 1938.

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California Doctors Spur Plans to Provide Mass Medical Aid

The California State Medical Association today was preparing to launch within two or three months a history-making plan for state-wide voluntary health insurance and hospitalization. With an overwhelming vote, the Association's House of Delegates in a meeting here approved a plan to set up a nonprofit corporation, financed by the Association, to administer the momentous project for the six thousand-member physicians and expected million or more subscribers.

Financial details of the undertaking were left to a special committee, but unofficial estimates placed the cost of health insurance and hospitalization at approximately $2.50 per subscribing member per month, with a sliding scale providing lower fees for dependents in a family.

May Set Wage Limit

The plan probably will be limited to persons with incomes under $2,500 a year. The exact figure will be established by the corporation after careful study.

Admittedly the voluntary medical plan was approved to forestall threatened governmental control of the profession.

The plan will be sufficiently broad to include hospital, nursing and laboratory fees in addition to physicians' and surgeons' services.

Dr. William W. Roblee of Riverside, President of the California Medical Association, explained:

"There will be absolutely no change in the traditional and ethical relationships between doctors and clients that now exist.

"A member of the group who is ill will go to his regular family doctor, who is a professional member. If upon diagnosis he is discovered to have appendicitis, for instance, he will be taken to the hospital of his choice and operated on by his physician in the regular manner.

"The only difference is the doctor will collect his money from the corporation and the patient will have paid his fee automatically by his monthly insurance premiums."

The project will be for low income groups, but is not intended to handle indigent cases, it was pointed out.

The plan will not provide medical care for alcoholics, persons afflicted with mental diseases or narcotic addicts. Also excluded will be injuries now covered by the workmen's compensation law.

Compensation for physicians will be on the basis of "units," rated according to the type of service given. At the start the unit value will be set arbitrarily, $2.00 now being considered as the temporary value.

Plan members will select their own hospitals and doctors. Payments will be made similar to life insurance premiums, and will be arranged on a weekly, monthly or semimonthly basis.

The program was adopted by a nine-to-one vote after three days of heated discussion by the 150 delegates from every county in the state, meeting in the auditorium of the Los Angeles County Medical Association Building.

Historical Step

It was called "a forward step in medical history" by Dr. Charles A. Dukes of Oakland, president-elect of the Medical Association.

"The plan guarantees the best possible medical attention to the average person by placing the services of competent physicians within his means," he said.

The nonprofit corporation administering the health insurance plan will be governed by a board of nine members—five doctors, two hospital superintendents and two business men. Every county medical unit will be represented by one member in the corporation.

In adopting the program the Association struck at so-called "chiselers" in the field of health insurance by voting to set up a special committee to pass on other health insurance plans with power to forbid members to affiliate with disapproved plans.

Association spokesmen said they were not intending to injure "reputable" coöperative groups.

Membership of medical men in the plan is optional with each individual doctor.

Three types of membership in the corporation will be provided—beneficiary, professional and administrative. The "premium" paying customers will comprise the beneficiary members.

Professional members will consist of the physicians and surgeons who voluntarily join the plan. Administrative members to operate the state-wide program will be elected by the corporation trustees.

Hospital Systems

The Association will underwrite three nonprofit hospitalization systems now in operation in the state, according to Dr. Lowell S. Goin, speaker of the House of Delegates. These systems include the Insurance Association of Approved Hospitals in the San Francisco-Oakland district, the Associated Service of Southern California and the Intercoast Hospital Service of Sacramento, which are providing care to about fifty thousand members at approximately 3 cents a day.

Only doctors who hold a medical degree and "an outstanding and unrevoked physicians' and surgeons' certificate," issued by the State Medical Board, would be entitled to professional membership.

A resolution demanding a referendum of the Association's members on the plan was defeated during the lively discussions.

Dr. Louis A. Alesen challenged the need for any type of socialized medicine.

"Are you sufficiently naïve," he demanded, "to believe that if you pass some type of health insurance that these outside groups will be satisfied? Does the individual live to serve the state or the state to serve the individual?"—Los Angeles *Herald and Express*, December 19.

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Medical Group to Operate Insurance System at Low Cost

By an overwhelming vote of its House of Delegates, the California State Medical Association yesterday ushered in a new era for medicine by adopting a plan for state-wide voluntary health insurance.

Unqualified indorsement given the program recommended by the Association's Council will make medical care available to low-income residents of the state "within two or three months" in return for small monthly premiums.

While financial details of the momentous project were left to a special committee, unofficial estimates placed the cost of the health insurance and hospitalization at approximately $2.50 for each member per month, with a sliding scale of lower fees for dependents in a family.

Will Affect Many

As an immediate result of yesterday's vote, machinery will be set in motion for establishment of a nonprofit corporation, financed by the Association, to "sell" and administer the project for the six thousand-member physicians and probable million or more subscribers.

Persons with incomes exceeding $2,500 per year will probably be barred from participation in the plan, although the official figure is to be set by the corporation after detailed study.

Passage of the revolutionary measures ended a stormy and heated two-day session of the 150 delegates, gathered from every county in the state in the auditorium of the Los Angeles County Medical Association Building.

San Francisco Proposal

Proposed by Dr. Karl Schaupp of San Francisco, Council president, and brought to the floor by Dr. P. K. Gilman, San Francisco, the principal enabling resolution read:

"Resolved, That the House of Delegates of the California Medical Association, in special session at Los Angeles . . . exercising its powers under the constitution of this Association, does hereby authorize, direct and empower the Council forthwith to cause to be created, fully organized and embarked upon its activities, a California nonprofit corporation, which shall have power to undertake a statewide voluntary medical service plan and shall, in fundamental principles, conform to the proposed plan submitted to the House of Delegates by the Council at this special session."

The approved and unparalleled voluntary medical setup was admittedly offered by the medical association to forestal threatened governmental control of the profession.

The plan is to be made broad enough to include hospital fees, nursing fees and laboratory charges as well as physicians' and surgeons' services.

Provides for Three Types of Membership

It provides for three types of membership in the corporation—beneficiary, professional and administrative. Beneficiary members will be the "premium-paying" customers.

Professional members will be the physicians and surgeons who voluntarily bind themselves to the plan and who will be paid out of a pool of subscription funds on the "unit" basis—with different medical treatments rated by units according to their complexity.

Administrative members will be elected by the corporation trustees and will operate the far-flung program.

"There will be absolutely no change in the traditional and ethical relationships between doctors and clients that now exist," Dr. William W. Roblee of Riverside, Association president, explained.

Example Reveals How Plan Will Work

"A member of the group who is ill will go to his regular family doctor who is a professional member. If upon diagnosis he is discovered to have appendicitis, for instance, he will be taken to the hospital of his choice, and operated on by his physician in the regular manner.

"The only difference is the doctor will collect his money from the corporation, and the patient will have paid his fee automatically by his monthly insurance premiums," he declared.

It was pointed out that the plan, when in effect, will be aimed at low-income groups, but will have nothing to do with indigent cases.

Three nonprofit hospitalization systems now in operation in the state will be underwritten by the Association, Dr. Lowell S. Goin, Speaker of the House of Delegates, declared.

These hospital prepayment insurance organizations are the Insurance Association of Approved Hospitals in the San Francisco-Oakland area, the Associated Hospital Service of Southern California, and the Intercoast Hospital Service of Sacramento, which are already supplying care at about 3 cents per day to approximately fifty thousand members.

"The scope of medical service is contemplated to include everything except industrial injuries, and accidents or illness arising from lawlessness, insanity, chronic alcoholism and drug addiction," the Council's report specified.

Regional directors will administer the insurance in various parts of the state, it continued, and only doctors who hold a medical degree and "an outstanding and unrevoked physicians' and surgeons' certificate," issued by the State Medical Board, would be eligible to professional membership.

Enrollment in the ranks of the California State Medical Association is not, however, compulsory for physicians who operate under the plan.

Socialized Medicine Need Challenged

Proponents and opponents of the revolutionary health insurance idea sparred verbally and heatedly throughout the morning.

While the delegates resolved themselves into a committee of the whole, the chairman, Doctor Roblee, opened the door to arguments.

After a lively battle, a resolution demanding a referendum of the Association's members before action of the House of Delegates was roundly defeated.

Hottest was the word tilt between Drs. Louis A. Alesen and Sam Ayres, Jr., of Los Angeles, in which Alesen challenged the need for any sort of socialized medicine.

"Are you sufficiently naïve to believe that if you pass some type of health insurance that these outside groups will be satisfied?" Doctor Alesen queried. "Does the individual live to serve the state or the state to serve the individual? That is the subject before the California Medical Association."

To which Doctor Ayres replied:

"When the patient says he is sick, you consult with other physicians on the matter. The public is that patient. It says, 'I'm sick' and we've got to find out what to do about it."

San Franciscans Favorable to Plan

Summing up the San Francisco opinion on the health insurance question, Dr. Alson E. Kilgore, surgeon, talked in favor of the plan.

He said: "Health insurance is coming, I am convinced, because of an underlying economic need that will not be denied. We have reached a point now where a large group in the community is not able to carry expenses of a major sickness."

An ominous warning was sounded by Dr. J. B. Harris of Sacramento, representative of the Medical Association at the state capital.

"The strains of the orchestra of the inaugural ball will hardly die away before there will be introduced in the Assembly the C. I. O. bill for compulsory health insurance in this state," he declared.

"We should have no delusion about what some of the legislators intend to do to us to break down our standards."

Another resolution unanimously passed provides for the establishment of a committee to serve other health insurance groups in the state and empowers the committee to pass upon the merits of such independent concerns.—Los Angeles *Examiner*, December 19.

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California Medicos Okeh Easy Pay Plan

California's six thousand doctors today were firmly launched on a new "poor man" medical plan, foreshadowing a knockdown and drag out fight with present group medical practitioners.

The doctors, through the House of Delegates of the California Medical Association, gave unqualified endorsement to a plan that would bring the most expensive type of operation, treatment of disease and medical guidance to the poor man for a flat monthly fee probably to be set at $2.50 a month, for the individual, or $6.00 a month for a family.

A possible fight with smaller health insurance enterprises was foreshadowed when the Association unanimously voted to set up a special committee to pass on all other health insurance plans now in operation.

The committee was empowered to forbid members to affiliate with any plans of which it disapproved. This, of course, was aimed at "chiselers," not reputable groups, it was explained.

Designed not for the rich man, nor the indigent who is entitled to free treatment, but for the working man, the new tentative plan, which goes into effect within sixty to ninety days, would be open to wage earners with incomes less than $2,500.

Passage of the revolutionary measures ended a heated two-day session of the 150 delegates gathered from every county in the state in the Los Angeles County Medical Association Building.

California became the first state in the union to attempt to meet the challenge of "state medicine."

In many ways its plan was patterned along the lines of such a state plan, except that it will be under control of doctors from start to finish.

As authorized, the Association would set up a nonprofit corporation. Three types of members would be sought—professional (the physician and surgeons who voluntarily join), the beneficiaries (patient members), and administrative members (those elected by the corporation trustees, charged with operating the plan).

Regional directors will administer the insurance in various parts of the state, and only doctors who hold a medical degree and "an outstanding and unrevoked physicians and surgeons' certificate" would be eligible to professional membership.

The entire plan is predicated on the unit system of payment, which, it is hoped, will guarantee the nonprofit corporation from going broke.

Under its provisions, the total dues of all member patients would go into a common fund. Each doctor who treated a member, meanwhile would be credited with so many points, according to the complexity of the treatment. When month's end arrived, the number of units would be divided into the total dollars—and the doctors would be paid off.

Dr. Charles A. Dukes of San Francisco, Chairman of the California Medical Association's Council, urged adoption of the plan as the "best possible medical care for the average man and woman of this state."

He said the entire medical profession has shown its willingness to coöperate.

Dr. Alson Kilgore of San Francisco, said the "basic principle of this coöperative plan of medicine and hospital service is widely recognized.

"While to us this may be a radical step it is none the less coming because of the underlying economic need. No one of us can deny there are large groups in every section who are unable to carry the costs of illness."

An ominous warning came from Dr. J. B. Harris of Sacramento, representative of the Medical Association at the state capital:

"The strains of the orchestra of the inaugural ball will hardly die away before there will be introduced in the Assembly the C. I. O. bill for compulsory health insurance in this state," he said.

"We should have no delusion about what some of the legislators intend to do to us to break down our standards."—Los Angeles *Evening News*, December 19.

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Medical Group Spurs Work on Insurance Plan

Lawyers Map Articles of Incorporation

The Council of the California State Medical Association proceeded promptly yesterday in its task of incorporating the organization which will administer the new state-wide plan of voluntary health insurance.

As the first step toward inauguration of a program making medical care available to low-income Californians on a small monthly premium basis, attorneys for the Association began work on articles of incorporation to be filed early next year.

The attorneys are: Hartley F. Peart, general counsel, and Howard Hassard, associate counsel.

Medical Approval

For their model the lawyers had an eleven-page tentative draft of incorporation articles approved by the Medical Association's House of Delegates at a meeting in Los Angeles Sunday.

Before the completed articles can be filed with the state government, corporation officers must be named. Dr. Karl L. Schaupp of San Francisco, President of the Association Council, yesterday said naming of these officers awaits an election by each of the nine councilor districts in the state. The election probably will be called when the Council meets here on January 14, he indicated.

Election Mapped

Association doctors in each councilor district will elect an administrative member to the health insurance plan corporation, and these members will, in turn, choose the trustees, who will direct actual operation of the program.

As local physicians returned from the Los Angeles meeting they were deluged with questions concerning operation of the plan—questions pertaining to eligibility, costs, kind of service and extent of treatment.

Doctor Schaupp and others met all such questions by pointing out that the Los Angeles meeting adopted merely the broad outlines of a plan and that details have not yet been worked out. Any questions pertaining to such details are premature, Doctor Schaupp said, and any answers to such questions are at present meaningless.

Finance Told

Dr. Charles A. Dukes of Oakland, president-elect of the State Medical Association and chairman of the special committee which drew the plan, however, declared that the new organization will be called the California Physicians' Service and will be financed, in the beginning, through a $5.00 assessment on each of the Association's six thousand members, plus a $15,000 loan from the Association.

Although reports from Los Angeles declared that the service, at first, will be limited to persons with annual income of less than $2,500, Doctor Dukes said:

"That question is far from decided. I am in favor of extending the service to include persons in the higher income brackets—those earning as much as $400 or $500 a month."

System Announced

At first, Doctor Dukes said, the plan will be opened only to "groups gainfully employed, such as the employees of reliable firms." Under these limitations, he said, the organization hopes to start out with 250,000 beneficiary members. Later, with virtually all limitations removed, 500,000 members are anticipated, he said.

Certain exceptions will probably be made in extending medical and hospital care, Doctor Dukes said, with no treatment for such ailments as mental diseases, venereal diseases, drug addiction, alcoholism, tuberculosis or injuries or diseases due to lawlessness or attempted suicide.

Doctor Dukes pointed out that the organization will be nonprofit, with doctors and hospitals receiving nominal fees.

"I hope and expect," he said, "that the monthly premium for an individual will be about $2.50."—San Francisco *Examiner*, December 20.

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Health Plan May Go Into Effect March 1

Details of Physicians' Program Being Worked Out by Committee; State Council Will Act; Final Organization to Be Submitted for Approval January 14

Actual operation of the California Medical Association's health insurance plan may start as early as next March, Dr. Charles A. Dukes of Oakland, President-elect of the Association and chairman of the committee which prepared the plan for submission to the Association's House of Delegates, foresaw today.

"It will take about three months to work out the details, and the state-wide doctor and hospital service to individuals paying monthly premiums could go into effect by March if there are no legal entanglements," Doctor Dukes said. "We hope to have it under way before the Association's next meeting at Del Monte in May."

The many details filling in the broad outline approved by the Association's House of Delegates in Los Angeles last week-end are now being developed by the original committee that submitted the plan, headed by Doctor Dukes, and including Dr. T. Henshaw Kelly and Dr. Lowell S. Goin.

Council to Act January 14

The completed plan will be submitted to the Council of the Medical Association, meeting here January 14.

It will be the Council which will form the organization, probably to be known as the California Physicians' Service, and actually put the service into effect, first electing an Executive Committee under authority given it by the House of Delegates.

Then, Doctor Dukes said, probably at the May meeting of the Association, each of the nine councilor districts in the state will elect an administrative member to the Health Insurance Plan Corporation.

These, he said, would appoint an executive group of trustees to include five doctors, two hospital men and two businessmen.

Meanwhile, Hartley F. Peart and Howard Hassard, attorneys for the Association, are working on articles of incorporation to be filed with the state government.

Plan Is Explained

All these details, Doctor Dukes pointed out, are dependent upon decisions to be made by the Association's Council at its January meeting.

This is the way in which Doctor Dukes foresees the plan will work out:

Eligibles: Groups of gainfully employed persons, possibly limited to those whose annual income is $2,500 or less, possibly including those whose income is as high as $5,000.

Cost: A flat monthly premium of approximately $2.50.

Exceptions to medical and hospital care: Mental diseases, venereal diseases, drug addiction, alcoholism, injuries or diseases due to lawlessness or attempted suicide, pulmonary tuberculosis (except for diagnosis and three weeks' treatment), hospitalization for cancer (except for diagnosis, therapeutic operations, or acute emergencies).

Doctor Dukes said it was hoped the service would start with 250,000 beneficiary members, eventually gaining 500,000 beneficiary members, by which time certain regulations of the plan might be relaxed.

Not included in privileges of membership would be drugs, biological and endocrine products, spectacles, artificial limbs and braces.

Beneficiary members would be permitted to choose their own doctors, from among those who are members of the California Physicians' Service.—San Francisco *News*, December 20.

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Fishbein Approves California Medical Association Health Plan

Chicago, December 18—(UP).—Dr. Morris Fishbein, editor of the *Journal of the American Medical Association*, said tonight that the California health insurance plan was in accordance with action taken by the American Medical Association's House of Delegates in Chicago last September.

"The delegates approved a plan for voluntary nonprofit cash indemnity insurance against the cost of sickness for people of the low-income group," Fishbein said.

"The California plan falls within this pattern."

He said he understood a similar plan was adopted by the Utah Medical Association last week and that health insurance also was being studied by the New York and Wisconsin state groups.—San Francisco *Chronicle*, December 19, 1938.

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Health Plan Held Immune to Trust Laws

California Medical Leaders Confident Insurance Is "in Clear" on Federal Statutes

Aid for Needy—Provisions Eliminate Charge of "Closed Corporation"; Two New Features Revealed

California medical leaders were confident yesterday that the new health insurance plan just authorized by the State Medical Association is "in the clear" so far as federal anti-trust statutes are concerned.

The plan's provision that any physician holding a license to practice in California may participate in the insurance system, regardless of whether he is a member of the State Medical Association, is believed to dispose of any charges of "closed corporation" or discrimination .

The provision was expressly inserted in the proposed Association's by-laws to avert any such attack as the government is now making on the American Medical Association in Washington, D. C.

Two New Features

Examination of the new health service's by-laws yesterday disclosed two hitherto unrevealed features of the program:

1. A provision that monthly fees to be charged may vary, for the same medical and hospitalization service, according to the differing abilities of beneficiaries to pay.

2. Authorization to enter into contracts with the federal government, the state or any city or county for provision of medical and hospitalization service.

The provision for differing fees will enable the service to extend health insurance into the very lowest income brackets as the plan develops, in the opinion of analysts of the plan. The contract authorization will enable the service to extend service even to indigents, by arrangement with governmental authorities.

May Assume Service

Medical service now provided SRA clients and to migrants and farm workers through various federal agencies may be taken over by the State Association organization, under this authorization, the governmental agencies, responsible now for their care footing the bill.

Fixing the upper income limit beyond which persons may not be eligible to the insurance rests with the service's board of governors, still to be elected. Although $2,500 has been discussed, informed observers believe the limit will be set as high as $3,500 or $4,000 when finally determined in order to extend the benefits of the plan as widely as possible.—San Francisco *Examiner*, December 21.

Southern California Itinerary: Doctors Dukes, Roblee, Kress, and Councilors Anderson, Emmons, Howson and Packard. For Months of January and February, 1939

Date	Day	City of Meeting	County Society Host	Secretary Host Society	Councilor	Guest Speakers
January 5	Thursday	Stockton	San Joaquin	G. H. Rohrbacker	Anderson	Roblee Kress
16	Monday	Orange	Orange	Glenn Curtis	Emmons	Dukes Kress
17	Tuesday	Pasadena	Los Angeles	L. G. Craig	Howson	Dukes Kress
18	Wednesday	Riverside	Riverside	R. A. Card	Emmons	Dukes Kress
19	Thursday	Los Angeles	Los Angeles	G. D. Maner	Howson	Dukes Kress
20	Friday	San Diego	San Diego	W. H. Newman	Emmons	Dukes Kress
21	Saturday	Imperial	Imperial	W. A. Clarke	Emmons	Dukes Kress
22	Sunday	No meeting	....	....	....	....
23	Monday	Ventura	Ventura	A. A. Morrison	Packard	Dukes Kress
24	Tuesday	Santa Barbara	Santa Barbara	J. J. Rupp	Packard	Dukes Kress
25	Wednesday	San Luis Obispo	San Luis Obispo	E. M. Bingham	Packard	Dukes Kress
February 16	Thursday	Bakersfield	Kern	C. S. Compton	Packard	Dukes Kress

C. M. A. DEPARTMENT OF PUBLIC RELATIONS[†]

MEDICAL AND SCIENTIFIC EXHIBITS AT THE GOLDEN GATE INTERNATIONAL EXPOSITION[*]

Had Hippocrates lived in 1939 he might have concluded, "And I will add to my own knowledge the findings of men of science and research."

On February 18 and 19, 1939, the World's Fair Première will give some 300,000 visitors an insight into the miracles of modern science and medicine. Officially, the premiere celebrates the construction of the two great bridges which span San Francisco Bay, the three great western power projects—Boulder, Grand Coulee, and Bonneville Dams—and the aerial "bridging" of the Pacific by the China Clipper. But man's equally miraculous achievements will be seen on Treasure Island itself by all who enter the huge Hall of Science.

There the vital and tenable results of thousands of hours of research and experiment will be on view. Illuminated dioramas, working models, robots, graphs, charts, and lectures will convey to Exposition visitors the wonders of modern scientific discoveries and their application. Every field of modern science will be represented: zoölogy, biology, chemistry, bacteriology, biochemistry, physics, etc. In the medical exhibits particular emphasis will be upon the prophylactic features of modern medicine.

Led by such famous institutions as the American Medical Association, the Mayo Clinic, and the American Dental Association, these exhibits will present a dramatic picture of the latest advances in medicine and related fields. In charge of the Hall of Science is Dr. Milton Silverman of the University of California.

Initial public demonstration of the remarkably effective antiserums for the thirty-two types of pneumococci will be made at the World's Fair Première. Specialists have predicted that the development and proper distribution of these curative agents will greatly diminish pneumonia mortality. With this demonstration the cause, spread, diagnosis, and treatment of the disease will be explained, as will the methods employed to determine the type of pneumococcus and the proper serum for its treatment.

Another exhibit will show human heart action by graphic light flashes in a gigantic model. The course of the blood stream will be shown; and the effects upon the heart of rest, of mild and severe exercise. Popular misconceptions of high blood pressure will be exposed and its prevention and treatment explained.

Part of the University of California's $300,000 exhibit will be a full-scale model of Dr. E. O. Lawrence's cyclotron. This enormous new weapon of medical science demonstrates the manner in which atomic structures are bombarded into their component parts. All details of construction have been faithfully reproduced. Instead of the invisible and deadly deuterons that whirl about the cyclotron vacuum chamber, steel balls will wind in slow spiral paths to represent their lightening-like motion.

The radio-active man, invention of the University of California's radiation laboratories, makes his first appearance at the première. This mechanical man receives into his body actual radio-active substances from the cyclotron. A Geiger counter, hooked up with a loudspeaker, indicates exactly where these substances flow. This radio-active man brings to light the latest research in the war on malignant diseases.

Other dramatic exhibits will show the discovery, history, and development of many curative products, among them quinin and insulin. Part of the Mayo Clinic exhibit will be a survey and analysis of the latest techniques in plastic surgery.

One of the keynote exhibits of the medical section is that sponsored by the American Medical Association under the direction of Dr. Thomas Hull. Emphasizing four important fields of health work, the Association will honor the heroes of medicine and trace the development of many important discoveries. It will explain the part played by the basic sciences—physics, chemistry, and zoölogy—and of such clinical fields as pediatrics, neurology, surgery, dermatology, obstetrics, urology, internal medicine, ophthalmology, and otolaryngology. The relation of medicine to public health comprises the third section of the Association's exhibit. The fourth will show the rôle of physics in modern medicine by animated explanations of the hypodermic and thermometer, the x-ray machine and the microscope.

The California Medical Association, through its Cancer Commission, is sponsoring one of the most vital exhibits in the Hall of Science. Nonsensational in character, this display gives accurate, nonevasive answers to such queries as: What is cancer? What causes it? Is it inheritable? How does cancer spread and cause death?

Demonstrations of chemicals and physical factors which have been found to cause cancer, demonstrations of diagnostic methods and explanations of types of curative treatments will be shown. This exhibit is under the direction of Dr. Alson Kilgore of the Cancer Commission, Dr. T. Henshaw Kelly of the State Medical Association, and Dr. Milton Silverman of the Advisory Committee.

The extensive use of chemistry in daily life will comprise a large section of the exhibit space in the Hall of Science. The rôle of chemical warfare to eliminate disease will be explained by a display showing the treatment of syphilis with modern heavy metal compounds and fever therapy; the treatment of malaria with the new synthetic substitutes for quinin; the treatment of coccal infections such as puerperal fever, streptococci bacteremia, certain types of pneumonia and gonorrhea.

The use of chemicals to fight human and animal disease carriers, and the part played by research chemistry in sanitation and public health, will also be dramatically presented.

A comparison of the ultimate cost of disasters to the nation as against the cost of their prevention will be graphically illustrated. Classifying disasters as "diseases of the social body," the American Red Cross will demonstrate the prevention, relief, and control of catastrophies.

An exhibit showing the use of daphnia magna as the ideal pharmacological test animal is expected to open up whole new fields of experimentation. A transparent crustacean, daphnia possesses well-developed muscular, nervous and glandular systems, hence it serves as an excellent test animal for detection of the presence or absence of substances affecting these systems.

ANNUAL REGISTRATION DUE ON JANUARY 1, 1939

Every practitioner of medicine and surgery holding a license to practice in California is required by law to register annually, on or before January 1, with the secretary-treasurer of the Board of Medical Examiners and at that time to pay a fee of $2. Failure to pay the required fee within sixty days after January 1 works a revocation of a license and thereafter a license may be reissued only after application and the payment of a $10 penalty.

The addresses of the offices of the Board of Medical Examiners of the State of California appear in every issue of

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[†] The complete roster of the Committee on Public Relations is printed on page 2 of the front advertising section of each issue. Dr. George G. Reinle of Oakland is the chairman and Dr. George H. Kress is the secretary. Component county societies and California Medical Association members are invited to present their problems to the committee. All communications should be sent to the director of the department, Dr. George H. Kress, Room 2004, Four Fifty Sutter Street, San Francisco.

[*] For California Medical Association cancer exhibit item, see page 51.

California and Western Medicine, under the roster of miscellaneous California medical organizations, at the bottom of advertising page 6.

RADIO PERIOD DIALOGUE ON STATE HUMANE DOG-POUND ACT (INITIATIVE NO. 2)

A radio broadcast against Initiative No. 2, and sponsored by the Los Angeles County Medical Association, was placed on the air prior to the November 8, 1938, state election. Because it may be of value to others when called upon to oppose the antivivisectionists groups, the script is given a place in this issue. Readers may enjoy reading the dialogue. (See advertising page 39 for the text.)

EXHIBIT OF PLANS FOR MODERN OFFICES FOR PHYSICIANS

At the 1939 annual meeting of the California Medical Association it is desired to have in the Scientific Exhibit a booth devoted to pictures and floor plans of modern offices for physicians.

The assistance of all members who have recently constructed new offices would be appreciated by the Scientific Committee, and if those who would help in this will send their names in to the central office of the Association, 450 Sutter, San Francisco, the Committee will then advise them as to further details of the exhibit.

PACIFIC STATES MEDICAL EXECUTIVES' CONFERENCE

The second Pacific Coast conference was held at Portland, Oregon, December 4. The meeting was attended by representatives from California, Idaho, Oregon, and Washington.

Organized medicine now finds itself faced with so many problems and so much to consider that every possible method of reaching solutions must be utilized. With expectation that the Pacific States might help one another in solution of similar problems, the first Pacific Coast conference was called in San Francisco last February. Those in attendance were impressed with the unity of needs of organized medicine in the Pacific region and, therefore, anticipated an even more valuable conference when Charles Sears, President of the Oregon State Medical Society, invited representatives from Arizona, California, Idaho, Nevada, and Washington to meet with the Oregon group in Portland.

Such similarity of problems and so many matters of regional interest were brought to light, and so much information was given on activities of neighboring state organizations, that the conference was established as a permanent organization. By-laws of the organization were presented by a committee of which Dr. George H. Kress of California was chairman. Henceforth it is to be known as the Pacific States Medical Executives' Conference and will draw its personnel from those in positions of responsibility in state associations of California, Idaho, Montana, Nevada, Oregon, Utah, Washington, and Wyoming. The next meeting is scheduled for Seattle.

The by-laws provide that the conference is not to be a legislative body, but is intended only to be mutually advisory and a means of trading ideas for solution of problems confronting state organizations of the Pacific region.

The most interesting feature of the Portland meeting was the discussion by members of the California delegation of plans to be brought before a special meeting of the California House of Delegates on December 17. Owing to the importance of the proposals revealed and the fact that they had not yet been officially acted on, the California participants requested that their discussion remain unreported. Official report of the coming meeting of the California House of Delegates will reveal the extensive nature of the far-reaching plans proposed for California. Those in attendance at the Portland conference appreciated the opportunity of this preview afforded by the California delegation, and the many questions brought out were evidence of the interest evoked.

Next in interest was the discussion of several federal activities in regard to medical care. The first discussion on these matters came from V. W. Spickard of Seattle, who warned of the attempts of welfare and social departments to obtain administrative authority over funds now appropriated and probably to be appropriated by the Federal Government in the coming legislative session. It was his thought that such funds, appropriated for furthering health activities, should be administered as far as possible through state boards of health or state health departments. It was suggested that the advantages of such power might be misused by such departments of health as were not in close contact with the aims and purposes of organized medicine. This objection, however, was answered when it was brought out that, as a general principle, state departments of health are usually more closely attuned to the ideals of organized medicine than are departments of social welfare. All representatives at the conference saw the importance of this suggestion, and a resolution was passed to the effect that each state organization make vigorous effort to have federal funds for health activities controlled by state departments of health rather than by departments of welfare.

As a portion of the discussion on federal funds, the proposals of the federal farm security plans for medical care were discussed. The consensus was that it is possible to handle this type of work only through county and local societies. Since it has been extremely difficult to get the federal administrator to accept any responsibility for statewide plans, it was brought out that the local societies should be cautioned against accepting fee schedules too small to provide adequate service. Fear was expressed that acceptance by one county society of very small fees might be used to influence other societies toward unpractical contracts.

The afternoon session of the conference brought out a discussion of methods of publicizing organization policies and activities to both the medical profession and the lay public. The meeting was closed after discussion by Martzloff of Oregon and Dudley of Washington on malpractice insurance. Oregon's plan of granting monopoly to one insurance carrier was explained in some detail by Martzloff. He stated that cost of insurance to members of the Oregon State Medical Society had by this plan been reduced to unbelievably low figures, suits had markedly diminished in number, and splendid coöperation had been obtained between the insurer and the society. Dudley explained the workings of the Washington State Medical Defense Fund.

Those in attendance at the meeting were Charles Sears, president of the Oregon State Medical Society, chairman of the conference: John Fitzgibbon, Portland, Oregon, delegate to the American Medical Association; Morris Bridgeman, Portland, secretary, Oregon State Medical Society; Mr. Clyde Foley, executive secretary, Oregon State Medical Society and secretary of the conference; Charles Manlove, hospital executive of Portland; Charles Hunt, Eugene, president-elect, Oregon State Medical Society; Karl Martzloff, Portland, member of the Council of the Oregon State Medical Society. Other members of the Council of the Oregon State Medical Society were Leslie Kent, Eugene; Frank Power, Salem, and George Henton, Portland. Ralph A. Fenton, Portland, trustee of the American Medical Association, was also present. Washington was represented by Harry Rhodehamel, Spokane, president of the Washington State Medical Association; V. W. Spickard, Seattle, secretary of the Washington State Medical Association; Mr. Jack Geoffroy, executive secretary, Washington State Medical Association; Ray Zech, Seattle, delegate to the American Medical Association; C. W. Knudson, president, King County Medical Society and

PACIFIC STATES MEDICAL EXECUTIVES' CONFERENCE, HELD IN PORTLAND, OREGON, SUNDAY, DECEMBER 4, 1938

Front row (Left to Right): Dr. J. N. Davis, Twin Falls, Idaho, Secretary, Idaho State Medical Association; Dr. Charles E. Sears, Portland, Oregon, President, Oregon State Medical Society; Dr. George G. Reinle, Oakland, California, Ex-President and Chairman of Committee on Public Relations, California Medical Association; Dr. Charles A. Dukes, Oakland, California, President-elect, California Medical Association; Dr. F. C. Gibson, Potlatch, Idaho, President, Idaho State Medical Association; Dr. Homer D. Dudley, Seattle, Washington, Chairman, Board of Governors of Defense Fund, Washington State Medical Association; Dr. V. W. Spickard, Seattle, Washington, Secretary-Treasurer, Washington State Medical Association; Dr. Herbert L. Hartley, Seattle, Washington, Assistant Editor of Northwest Medicine, Washington State Medical Association; Dr. George E. Henton, Portland, Oregon, Third Vice-President, Oregon State Medical Society.

Middle row (Left to Right): Mr. Jack M. Geoffroy, Seattle, Washington, Executive Secretary, Washington State Medical Association; Dr. S. P. Cromer, Chicago, Illinois, member of the staff of the Council on Medical Education and Hospitals of the American Medical Association; Dr. Clarence W. Knutson, Seattle, Washington, President, Public Health League of Washington; Dr. Raymond L. Zech, Seattle, Washington, Delegate to the American Medical Association, Washington State Medical Association; Dr. C. H. Manlove, Portland, Oregon, Superintendent, Good Samaritan Hospital and representing the Oregon Association of Hospitals, Oregon State Medical Society; Dr. Richard B. Adams, Portland, Oregon, member, Committee on Public Policy, Oregon State Medical Society; Dr. John H. Fitzgibbon, Portland, Oregon, Delegate to American Medical Association, Oregon State Medical Society; Dr. Albert I. Bouffleur, Seattle; Mr. Clyde C. Foley, Executive Secretary, Oregon State Medical Society; Dr. L. S. Kent, Eugene, Oregon, Councilor-at-large, Oregon State Medical Society; Dr. Stanley Lamb, Portland, Oregon; Dr. Charles E. Hunt, Eugene, Oregon, President-elect, Oregon State Medical Society; Dr. F. B. Freeland, Warm Springs, Oregon; Dr. W. H. Buermann, Portland, Oregon; Dr. George H. Kress, San Francisco, California, Secretary, California Medical Association.

Back row (Left to Right): Dr. H. E. Rhodehamel, Spokane, Washington, President, Washington State Medical Association; Dr. J. C. Hayes, Medford, Oregon, Councilor, Fourth District, Oregon State Medical Society; Dr. Morris L. Bridgeman, Portland, Oregon, Secretary, Oregon State Medical Society; Mr. John J. Coughlin, Portland, Oregon, Legal Counsel, Oregon State Medical Society; Dr. C. W. McCain, Hood River, Oregon, President, Mid-Columbia Medical Society; Dr. R. W. Hemingway, Bend, Oregon, Councilor, Fifth District, Oregon State Medical Society; Dr. H. R. Kauffman, Toledo, Oregon; Dr. Guy L. Boyden, Portland, Oregon, Councilor, First District, Oregon State Medical Society; Dr. L. M. Bain, Albany, Oregon, Secretary, Linn County Medical Society; Dr. F. L. Ralston, La Grande, Oregon, Second Vice-President, Oregon State Medical Society; Dr. H. M. Francis, Corvallis, Oregon; Dr. F. K. Power, Salem, Oregon, member, Bureau of Medical Economics, Oregon State Medical Society.

Washington Public Health League; H. D. Dudley, Seattle, director of the Medical Defense Fund; and H. L. Hartley, Seattle, assistant editor, *Northwest Medicine.* Idaho was represented by Frank Gibson, Potlach, president, Idaho State Medical Association, and J. N. Davis, Twin Falls, secretary. The California delegation consisted of Charles Dukes, Oakland, president-elect of the California Medical Association; George Reinle, Oakland, chairman of Public Relations Committee of California Medical Association, and George H. Kress, San Francisco, secretary of the California Medical Association and editor of CALIFORNIA AND WESTERN MEDICINE.

EXHIBIT AT THE GOLDEN GATE FAIR*

Causes and Cure of Cancer

Organized medicine will teach the public that the cause of cancer may lurk in about forty innocent-appearing chemicals, and even overexposure of the body to light, in a special exhibit at the 1939 Exposition, it was learned yesterday.

The exhibit, to be sponsored by the California Medical Society, will vividly display the chemicals involved, most of which are derivatives or impurities of coal tar and some types of paraffin.

The coal-tar products are used to make aniline dyes, aromatic substances and other articles coming into increased use with the advance of chemistry into industry.

A Warning

The medical exhibit will warn the public against excessive doses of strong light and heat, such as sun bathing or overexposure to any form of lamp rays, and against repeated contact with radium substances.

The cancer specialists said they would teach that chronic irritation, injury, and infection could help to give cancer a start, but, they added, "contrary to popular belief, these alone never cause cancer."

"Cancer can be cured," said another pronouncement, "but cure is possible only if the disease is recognized early and treatment is started before the disease has spread."

The exhibit will include graphs, showing the proportionate decline of the patient's chances as the disease spreads.

In lip cancer they will say that all cases can be cured if caught before the disease agent reached one gland; 70 per cent can be cured after spreading to only one gland under the jaw; and 40 per cent after reaching two glands.

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* For other article on the Fair, see page 49.

Chances of Cure

It will say, further, that cancer of the breast can be cured in 70 per cent of the cases if caught before reaching one arm-pit gland; in 18 per cent after reaching one gland there; but in only 5 per cent of cases after spreading to two arm-pit glands.

The exhibit will be under the supervision of Dr. T. Henshaw Kelly of the California Medical Society; Dr. Alson Kilgore of the California Cancer Commission, a division of the State Medical Association; and Dr. Milton Silverman, head of the Exposition's science staff.—San Francisco *Chronicle*, December 26, 1938.

COMPONENT COUNTY MEDICAL SOCIETIES

HUMBOLDT COUNTY

The Humboldt County Medical Society met on the evening of November 7 at the Eureka Inn.

The meeting was presided over by the president, Dr. Francis Stump. Twenty-one members and the following visitors were present: Dr. William W. Roblee, President of the California Medical Association; Dr. George H. Kress, Secretary of the State Association; and Dr. Henry S. Rogers, Councilor of the Ninth District.

Dr. Max Goodman of Eureka presented an excellent paper, and the visiting officers spoke on action and legislation of the State Association and the coöperation the county societies can give the State officers.

The following officers were elected for the year 1939: Samuel P. Burre, president; John S. Chain, vice-president; John A. Lane, treasurer; Joseph S. Woolford, secretary; Wilson Stegeman, delegate; Lane Falk, alternate.

Lawrence A. Wing, *Secretary*.

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MARIN COUNTY

Dr. Karl A. Schaupp addressed the combined meeting of the Marin County Medical Society and its Auxiliary on the present outlook regarding medicine in California. There was a good attendance at the meeting, which was held at the Marin Golf and Country Club, and all were well pleased with his explanation of the situation.

Carl W. Clark, *Secretary*.

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MENDOCINO-LAKE COUNTY

The members of the Mendocino-Lake County Medical Society were guests of Doctor Cushman at Talmage on Saturday evening, December 10, 1938, at 7:30 o'clock. The doctors' wives, as well as the dentists and their wives, were invited. The dinner was followed by two movies, furnished by Dr. William P. Shepherd of the Metropolitan Life Insurance Company. The subject matter of these movies dealt with *Pneumonia*—one of them for lay audiences, and the other for physicians. Dr. George H. Kress, Secretary of the California Medical Association, was present and spoke on *Problems in Medical Organization*.

Report was made on the gratifying election returns on Amendment No. 2.

Attention was called to the special meeting of the House of Delegates, scheduled for December 17, to consider a state-wide health service.

Robert B. Smalley, *Secretary*.

⁂

SACRAMENTO COUNTY

The regular meeting of the Sacramento Society for Medical Improvement was called to order by the president, Dr. Dave Dozier, on November 15, 1938, at the Auditorium. There were seventy-two members and guests present.

The society was honored by the presence of Dr. William W. Roblee, President of the California Medical Association, and Dr. George H. Kress, the Association Secretary. Doctor Roblee discussed *The Functions of the California Medical Association*, and the important subject of *Medical Service Plans*. A brief outline of the plan now being formulated by the California Medical Association was presented. Doctor Kress discussed *Present Medical Trends and the Postgraduate Conferences*. After some discussion a motion was made by Doctor Ankele that the Sacramento Society for Medical Improvement endorse and support the action of the Council of the California Medical Association in working out plans for medical care. The motion was passed.

The applications for membership of Drs. W. Harding, J. Dillon, and A. M. Henderson, Jr., were read for the first time.

Dr. Ralph Teall made a motion that the Society express its appreciation to the Womans' Auxiliary for the able assistance given in the recent election to defeat Proposition No. 2. The motion passed unanimously.

There being no further business the meeting was adjourned.

G. E. Millar, *Secretary*.

⁂

SAN JOAQUIN COUNTY

The regular annual supper meeting of the San Joaquin County Medical Society was held at the Hotel Wolf roof garden, December 1, 1938. The meeting was called to order by the president, Dr. A. C. Boehmer, at 7:45 p. m.

A motion from the floor was made that the reading of the minutes of the preceding meeting and the financial statement of the secretary be dispensed with. The motion carried.

The Election Committee reported the following results on the ballot for officers of 1939: N. P. Johnson, president; Frank Vieira, first vice-president; R. L. Owens, second vice-president; G. H. Rohrbacher, secretary-treasurer; A. C. Boehmer, J. O. Eccleston, T. W. Kyddson, D. R. Powell, H. C. Rixford, V. R. Ross, and G. K. Wever, directors; Frank Doughty, G. H. Sanderson, and Dewey Powell, delegates; C. A. Broaddus, R. T. McGurk, and C. V. Thompson, alternates.

Dr. Dewey Powell delivered a eulogy on the passing of Dr. Elmer William Weirich of Angels Camp.

Doctor Eccleston announced that there would be a new form for the American Medical Association survey presented to the Society in the next week or ten days, and asked for coöperation in the filling out of it.

Dr. C. A. Broaddus presented the certificates of those who were accepted as Fellows in the Medical Academy of Graduate Study.

President A. C. Boehmer stated that this was the last meeting he would preside over, as he will be in Chicago in January. He thanked the Board of Directors and the Society for a successful year.

The paper of the evening was presented by Dr. Leo Eloesser of the surgical staff of the Stanford Medical School. Doctor Eloesser sketched the political results for the civil war in Spain and talked on the *Medical Problem of the War as Viewed from the Loyalists' Side*. His paper was illustrated by lantern slides, showing the equipment used and types of field hospitals. This paper was extremely interesting and caused considerable comment and questions from the floor.

There being no further business to come before the Society, the meeting was adjourned at 11:05 p. m.

G. H. Rohrbacher, *Secretary*.

⁂

TULARE COUNTY

A regular meeting of the Tulare County Medical Society was held at the Hotel Johnson, Visalia, at 7 p. m., on November 27, 1938. President Elmo Zumwalt called the meeting to order.

Our district councilor, Dr. A. E. Anderson, was present and took up various organization problems. He discussed the *Plan of Medical Service Insurance* which has been devised by the California Medical Association and urged us to send our delegate to the December meeting. He reported on the appointment of Doctor Scarbrough as district medical advisor for the Agricultural Workers Health and Medical Association. Another plea was made for postgraduate conferences to be held in this district.

The president appointed Dr. Austin Miller of Porterville to attend the December meeting in Los Angeles as delegate from the Tulare County Medical Society.

Dr. Max Goldstein of Fresno was next introduced as guest speaker of the evening. He discussed the *Common Eye, Ear, Nose, and Throat Conditions and Treatment.* The talk was of a very practical nature, and many useful procedures were brought to our attention. A vote of thanks was extended Doctor Goldstein for his efforts in coming to speak to us.

The business session of the evening included the reading of accumulated correspondence. The first subject dealt with the submitted schedule of fees for the Agricultural Workers' Health and Medical Association.

A request was made to have the newly appointed district medical advisor, Doctor Scarbrough, attend our next meeting so that we might clarify the various points in the fee schedule.

A letter was received from *Life* in acknowledgment of our telegram in behalf of their illustrated article regarding animal experimentation.

A letter was read from the Nurses' Association of Tulare County, specifying the new eight-hour duty plan. This was endorsed by the Tulare County Medical Society.

A communication from the Southern California Society for the Control of Syphilis and Gonorrhea was given consideration.

Because of the lateness of the hour, further business was postponed until the next regular meeting. Adjournment took place at 11:30 p. m.

Present at the meeting were Dr. M. Goldstein of Fresno, guest speaker of the evening; Dr. A. E. Anderson, district councilor of Fresno; and the following members and guests: Doctors Zumwalt, Seligman, Betts, Hardin, Kohn, Austin Miller, Fillmore, Burton, Weiss, DeBusk, Ruth, Brigham, P. Miller, Falk, Cronemiller, Powell, Rogers, Annie Bond, Lipson, Zeller, Rosson, Mathias, Zink, Watke, Ginsburg, Seiberth, Ireton, Guido, Neale, and Mr. Carroll.

KARL F. WEISS, *Secretary.*

CHANGES IN MEMBERSHIP

New Members (4)

Alameda County

Robert L. Matteo
A. H. Rice

San Diego County

George E. Zukovich

San Francisco County

Konstantine I. Berejkoff

Transferred (7)

Nathan A. Dubin, from San Diego County to Placer County.

Alice Fath, from San Francisco County to Merced County.

C. T. Halburg, from Los Angeles County to San Bernardino County.

Francis T. Raymond, from Riverside County to Orange County.

P. R. Shumaker, from San Joaquin County to Alameda County.

Harry B. Torrey, from Santa Clara County to Alameda County.

Burnett W. Wright, from Los Angeles County to Nashville Academy of Medicine.

In Memoriam

Dundas, Robert Chester. Died at Los Angeles, November 20, 1938, age 70. Graduate of Rush Medical College, University of Chicago, 1890. Licensed in California in 1897. Doctor Dundas was a member of the Los Angeles County Medical Association, the California Medical Association, and the American Medical Association.

✝

Fitzpatrick, Earl Berton. Died at Martinez, December 11, 1938, age 51. Graduate of the Oakland College of Medicine and Surgery, 1910, and licensed in California the same year. Doctor Fitzpatrick was a member of the Contra Costa County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

✝

Petty, Charles Odell. Died at Fullerton, November 17, 1938, age 67. Graduate of Gross Medical College, Denver, 1900. Licensed in California in 1915. Doctor Petty was a member of the Orange County Medical Society, the California Medical Association, and the American Medical Association.

✝

Potter, Clarence Denver. Died at Berkeley, December 8, 1938. Graduate of Hahnemann Medical College of the Pacific, San Francisco, 1896, and licensed in California the same year. Doctor Potter was a member of the San Francisco County Medical Association, the California Medical Association, and the American Medical Association.

✝

Scribner, Richard George. Died at Sacramento, November 19, 1938, age 45. Graduate of the University of California Medical School, San Francisco, 1921, and licensed in California the same year. Doctor Scribner was a member of the Sacramento Society for Medical Improvement, the California Medical Association, and the American Medical Association.

✝

Sundin, Peter Olaf. Died at Los Angeles, November 29, 1938, age 61. Graduate of the University of Southern California School of Medicine, Los Angeles, 1907, and licensed in California the same year. Doctor Sundin was a member of the Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

✝

Weirich, Elmer Williams. Died at Angels Camp, November 20, 1938, age 72. Graduate of Hahnemann Medical College of the Pacific, San Francisco, 1889. Licensed in California in 1890. Doctor Weirich was a retired member of the San Joaquin County Medical Society, the California Medical Association, and the American Medical Association.

✝

OBITUARIES

Victor G. Vecki

1857–1938

The recent death of this pioneer member of our society closed a life more full than the average of experience, travel, professional attainment, and culture. Born in 1857 in Zagreb, Jugoslavia, Doctor Vecki was educated in the schools of that city. He received his college education in the Imperial and Royal University of Vienna, where he also was given his medical degree in 1881. He was a captain in the Austro-Hungarian Army, and Royal Croatian Sanitary Councilor. He came to California in 1892, practicing the first four years in San Jose. He entered practice in San Francisco in 1896. In the first years he had a large general practice, but was one of the pioneers in this city in the speciality of urology. One of his colleagues recently died, Dr. Louis Bazet; and another is still with us and very active, Dr. Paul Campeche.

Doctor Vecki was a member of the American Urological Society, the California State Medical Association, and a Fellow of the American Medical Association. He was our State Medical Society delegate to the latter society for about thirteen years, and was instrumental in bringing the national convention here in 1923. He was the author of many medical articles as well as nonmedical. His latest work was a revision last year of his book on the prevention of premature senility.

Doctor Vecki worked steadily until the beginning of this year and was in his office at intervals up till sixteen days from his death. In his passing we have lost another pioneer of the horse-and-buggy days, a man who was unusually well educated in medicine, and who was well versed in all the phases of the art of living. His widow survives him, as do three sons, Victor J. Vecki, D.D.S.; Marion Vecki, attorney at law; and Morrell Vecki, a member of the San Francisco County Medical Society.

H. M. F. Behneman, M.D.

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Elmer William Weirich
1885–1938

Dr. Elmer William Weirich of Angels Camp, Calaveras County, long a member in good standing in the San Joaquin County Medical Society, passed from this life at his home in Angels Camp on Sunday, November 20, 1938.

Doctor Weirich, a native of Massillon, Ohio, had lived in California fifty-three years, forty-two of which were spent in Angels Camp and the remainder in San Francisco, Murphys, and Copperopolis. For a time he was company physician for the Calaveras Copper Company at Copperopolis, and later in Angels Camp he was physician for the employees of the Carson Hill Mine at Melones. For more than twenty years he was superintendent of the Calaveras County Hospital at San Andreas. Ill health forced his retirement three years ago.

Doctor Weirich was a typical country doctor, administering to the sick. Those unable to pay received the same kindly service as those who could afford to pay. He never hesitated to accept a call, night or day, and was ever ready to aid those in distress.

A leader in his community, he took a deep interest in local, state and national affairs, and for years was active in Republican Party political affairs of the state and served on the County Republican Central Committee for many years.

As owner of a ranch property on the Murphys grade road, he became interested in the affairs of the Calaveras Water Users' Association, and for a number of years was president of that organization and led the fight for irrigation water service in behalf of the farmers in the Angels-Murphys section. He was also a charter member of the Angels Booster Club.

Surviving are his wife, two daughters, both living in Angels Camp, a sister in Ohio, and three grandchildren. To these members of the family the San Joaquin County Medical Society express the very high regard in which Doctor Weirich was held, and extend to them our sincere sympathy in their great loss.

Dewey Powell, M.D.

THE WOMAN'S AUXILIARY TO THE CALIFORNIA MEDICAL ASSOCIATION[†]

MRS. CLIFFORD A. WRIGHT..............................President
MRS. FRED H. ZUMWALT..............Chairman on Publicity
MRS. FRANK H. BODIN..Assistant Chairman on Publicity

Component County Auxiliaries

Alameda County

A book review of the "Horse and Buggy Doctor" by Alfred E. Hertzler, M. D., was given by Mrs. James E. Wales at the regular meeting of the Woman's Auxiliary to the Alameda County Medical Association. The meeting was held at the Claremont Country Club on November 18.

Mrs. A. A. Alexander arranged a very interesting exhibit of medical equipment of the horse and buggy era.

Members brought old toys to be repaired for use at the Toy Loan Center.

Mrs. H. J. Templeton, a member of the Auxiliary, entertained with vocal selections, accompanied by Mrs. F. A. Bennett.

Mrs. Charles A. Dukes was the hostess of the day, assisted by Mrs. Harry Akesson, who was chairman of reservations.

Mrs. Grant Ellis, *Publicity Chairman.*

⁂

Fresno County

On November 1, Dr. Margaret Smythe, director of the State Hospital for the Insane at Stockton, was the hostess to the members of the Woman's Auxiliary to the Fresno County Medical Society.

It was very interesting and a privilege to walk through the grounds and buildings to see the inmates at their various routine duties. Of particular interest were the descriptions of various cases, the satisfactory response to proper care and the progress made.

Doctor Smythe expressed a desire and stressed the need for a separate institution for children, especially those of adolescent age. In separating the youth from adults more effective measures toward a complete cure might be accomplished.

The group were entertained for luncheon by Doctor Smythe in her beautiful colonial home.

Those who were present went home with the memory and satisfaction of a very pleasant and profitable day.

* * *

The University-Sequoia Club was the setting for the annual Hygeia benefit and Christmas party given by the Fresno Woman's Auxiliary on December 6, 1938.

Thirty-seven doctors' wives reserved tables and brought their friends for an enjoyable evening of bridge. The members and guests were received by the president, Mrs. C. M. Vanderburg, assisted by Mrs. Guy Manson.

The doctors of the County Medical Society met on the same evening in the University-Sequoia Club, and at the conclusion of their meeting joined the ladies for a social hour and refreshments.

Mrs. Charles H. Ingram, *Publicity Chairman.*

[†] As county auxiliaries of the Woman's Auxiliary to the California Medical Association are formed, the names of their officers should be forwarded to Mrs. Frank H. Rodin, Assistant Chairman of the Publicity and Publications Committee, 2457 Bay Street, San Francisco. Brief reports of county auxiliary meetings will be welcomed by Mrs. Rodin and must be sent to her before publication takes place in this column. For lists of state and county officers, see advertising page 6. The Council of the California Medical Association has instructed the Editor to allocate two pages in every issue to Woman's Auxiliary notes.

Kern County

In October the Woman's Auxiliary to the Kern County Medical Association met at the home of Mrs. P. N. Root. The program for the evening included a book review of Dr. Alfred E. Hertzler's "Horse and Buggy Doctor."

* * *

The members of the Kern County Medical Association met jointly with the Woman's Auxiliary and guests for dinner in November.

The guest speaker, Dr. Leo Eloesser, gave a description of *Medical Aspects of the Present War in Spain.*

Mrs. John J. McCarthy, *Secretary.*

⁂

Los Angeles County

The Woman's Auxiliary to the Los Angeles County Medical Society met at the County Medical Building on November 22, 1938, at 12 noon. The president, Mrs. William H. Leake, presided.

The guest speakers were: Judge Charles W. Fricke of the Superior Court of Los Angeles, who spoke on *Expert Testimony and How a Doctor Should Address a Jury,* and Mr. Clarence George, local editor, who spoke on *Personality.*

Mrs. Leake thanked the members for their splendid work during the recent political campaign.

* * *

Approximately $200 was raised at a benefit given on November 29 for Christmas baskets to be distributed to needy families.

Over two hundred doctors and their wives attended the performance of "The Three-Cornered Moon," directed by Mr. Henry Duffy at the Las Palmas Theater.

The president, Mrs. William H. Leake, and her committee, which included Mesdames A. Brockway, J. Martin Askey, William Daniel, C. W. Irish, Paul D. Foster and Karl Von Hagen, were gratified by the large attendance and the success of the undertaking.

Mrs. Karl Von Hagen, *Publicity Chairman.*

⁂

Marin County

The Sleepy Hollow Country Club was the meeting place for the Woman's Auxiliary to the Marin County Medical Association on October 27 at the dinner hour. The president, Mrs. Bernard Conroy, presided. Twenty-four members were present.

Mrs. Conroy appointed the following chairmen: Mrs. F. Lowe, Membership and Organization; Mrs. Robert Furlong, Program and Health; Mesdames A. Miller and D. Fowler, Hygeia; Mrs. G. Landrock, Public Relations; and Mrs. C. DeLancey, Publicity.

A letter was read inviting the Auxiliary to send a delegate to a community meeting for the consideration of organizing a county health clinic and the appointment of a county health officer. After thoroughly discussing the subject the matter was referred to the Advisory Committee of the Marin County Medical Society, who were meeting at the same time and place. They ruled that the Auxiliary may send an uninstructed delegate to the meeting.

Mrs. Conroy introduced Mrs. Frank H. Rodin, the guest speaker, whose subject was *Health Education.* She caused the members to feel that they had an important part and definite responsibility in spreading the knowledge of healthy living in our community.

* * *

A very interesting program was presented to the members and guests of the Woman's Auxiliary of Marin County at their dinner meeting held at the Marin Golf and Country Club at 7 p. m., on December 2. The president, Mrs. Bernard Conroy, presided. Twenty-three members were present.

A committee of six was appointed to make the necessary arrangements for a bridge tea to be given in January, the proceeds of which are to be used for a philanthropic project.

The doctors of the Marin County Medical Association meeting at the same time and place, discovered after dinner that they were without a speaker, so they joined the women for their program.

Mrs. Conroy introduced the speakers of the evening: Dr. Henry Rogers, Councilor for the Ninth District, spoke on *The Farmers' Reaction to Socialized Medicine.*

Dr. Karl Schaupp, a member of the Committee on Hospitals, Dispensaries, and Clinics, presented a very clear and definite outline of *A State Socialized Medical Program.* He advised the medical profession to study the proposed plans and take an active interest now, rather than "wake up" and find a program forced upon them that might be neither agreeable nor practical. "A medical program of necessity should be framed by a medical group."

Mrs. C. A. De Lancey, *Publicity Chairman.*

⁂

Sacramento County

The November meeting of the Woman's Auxiliary to the Sacramento Society for Medical Improvement was held at the home of Mrs. Burt Howard.

After an interesting business meeting, Mrs. Harold Trimble, State Chairman of Hygeia, spoke to the members of the importance of the *Hygeia,* health magazine, to the Auxiliary and the community, urging the members to subscribe and also to interest their friends in subscribing.

The Auxiliary was entertained by a tableau, *The Seven Ages of Man,* ably presented by the following members: Mesdames George Spencer, W. Pope, S. Christian, Gustave Wilson, M. Lipp, Glen Harding, and James Yant.

Mrs. O. F. Johnson, *Publicity Chairman.*

⁂

San Diego County

The fourth and very successful Public Health Institute was held by the Woman's Auxiliary to the San Diego County Medical Society on November 1 at the House of Hospitality in Balboa Park.

This Public Health Institute was arranged to provide authentic scientific medical information to the community of San Diego.

Mrs. F. J. Lindenmulder was chairman of program, assisted by Mesdames C. O. Tanner, Emil Black, R. A. Schneider, and E. H. Christopherson, who acted as ushers.

The program was divided into two sessions, both of which were very well attended. At the morning session, subjects concerning the health of the school child were presented as follows:

Dr. S. J. McClendon, pediatrician, discussed *The Problems of Contagious Diseases of the School Child,* stressing the importance of the early prevention of contagious diseases.

An illustrated talk on the *Care of the School Child's Teeth* was given by Dr. Harvey Stallard, dentist.

Dr. R. Emerson Bond spoke on *Pertinent Legislation.*

The mothers of growing children were especially invited to attend this institute.

The evening session took place in the auditorium of the House of Hospitality at 8 p. m.

Dr. C. O. Tanner opened the evening session with a talk on *Pertinent Legislation.*

The Control of Venereal Diseases as a Government Function was presented by Dr. Ralph Mullenix.

A panel discussion on *Tuberculosis* was led by Mrs. Willard Newman, with Doctors Bryant Simpson, President of the San Diego County Medical Society, Stephen A. Parowski, and R. A. Schneiders discussing the subject and answering questions from the floor.

Mrs. H. K. Albertson, *Publicity Chairman.*

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San Joaquin County

The December meeting of the Woman's Auxiliary to the San Joaquin County Medical Society was held at the home of Mrs. Percy B. Gallegos. Twenty-four members were present.

The Auxiliary is carrying on a plan which was adopted last year. Each member contributes $1 to the Hygeia Fund, which enables them to place subscriptions to *Hygeia* in schools, beauty shops, clubs for adolescent children, and other organizations.

At the conclusion of the business meeting a delightful program of Christmas tales and music was presented by the talented new member, Mrs. Ellis Harbert.

A social hour concluded the meeting.

Mrs. George K. Wever, *President.*

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San Mateo County

The doctors of the San Mateo County Medical Society were the guests of the Woman's Auxiliary at their meeting on November 16 at the Benjamin Franklin Hotel.

The guest speaker, Dr. Chauncey Leake, chief of the Department of Pharmacology at the University of California, gave a very enlightening talk on *Drug Foolishness.* An interesting question period followed, and at the conclusion Dr. Paul Hanzlik discussed the subject for fifteen minutes.

* * *

The next meeting will take place at the Benjamin Franklin Hotel on January 23, where the members will meet for dinner.

Following the business meeting, Mrs. Paul Hanzlik will give a book review.

Mrs. J. G. Brigman, *Publicity Chairman.*

*

Santa Cruz County

The president, Mrs. Alfred L. Phillips, presided at the luncheon meeting of the Woman's Auxiliary to the Santa Cruz County Medical Society at Deer Park Tavern on November 28.

Doctor Havenhill gave a talk on the *Prevention and Cure of Cancer,* illustrated by pictures and microscopic slides.

Due to holiday activities, it was voted that there would be no meeting in December. The next regular meeting will take place in January, at which time *Socialized Medicine* will be discussed. Mrs. R. C. Alsberg,

Recording Secretary and Publicity Chairman.

NEVADA STATE MEDICAL ASSOCIATION

Minutes of the Thirty-Fifth Annual Meeting of the Nevada State Medical Association, Held at Reno, Nevada, September 23–24, 1938 †

The thirty-fifth annual meeting of the Nevada State Medical Association was called to order at 9:45 a. m. at Bowers Mansion, with President Harry W. Sawyer, presiding.

Doctor Sawyer then gave the president's address.*

Program

Friday, September 23, 1938

After the address of President Sawyer, the scientific program was commenced and the following papers were presented:

Chronic Allergy in Medical Practice, by Albert H. Rowe of Oakland, California. Discussed by J. A. Fuller and Earle L. Creveling.

Postoperative Distention: Prevention and Treatment, by A. R. Kilgore of San Francisco, California.

Kidney Infections: Pyelographic Diagnosis, by Miley B. Wesson of San Francisco.

Mental Disease as Met in General Practice, by R. A. Cushman of Talmage, California.

This concluded the scientific program for the day and recess was taken for lunch, which was served in the patio at Bowers Mansion.

Saturday, September 24, 1938

The meeting was called to order at Bowers Mansion at 9:40 a. m. by President H. W. Sawyer. The scientific program was immediately taken up and was as follows:

Complications of Pneumonia, by Philip King Brown of San Francisco.

Gastric and Duodenal Ulcer—The Case Against Gastroenterostomy, by Ernst Gehrels of San Francisco.

The Common Proctologic Disorders, by William H. Daniel of Los Angeles. Illustrated with motion pictures.

New Anesthetics and Methods—Carbon Dioxid Absorption with Cyclopropane, by A. R. Da Costa of Reno. Motion-picture demonstration.

Congenital Syphilis, by L. R. Brigman of Reno.

American Medical Association Radio Broadcasts.—The fourth series of programs broadcast in dramatic form portraying fictitious but typical incidents of significance in relation to health by the American Medical Association and the National Broadcasting Company, entitled "Your Health," began Wednesday, October 19, and will run consecutively for thirty-six weeks, *The Journal of the American Medical Association* for November 19 anounces. The program is broadcast over the Blue network of the National Broadcasting Company each Wednesday at 2 p. m. eastern standard time (1 p. m. central standard time, 12 noon mountain time, 11 a. m. Pacific time).

These programs are broadcast on what is known in radio as a sustaining basis; that is, the time is furnished gratis by the radio network and local stations and no revenue is derived from the programs. Therefore, local stations may or may not take the program, at their discretion, except those stations which are owned and operated by the National Broadcasting Company.

When to Select a Physician.—Before any medical emergency knocks at your door, become acquainted with a physician you know is reliable and, above all, who knows you, is the advice given by Edward D. Nix, Chicago, in "Beating Trouble to the Punch," appearing in the January issue of *Hygeia, the Health Magazine.*

To you who have moved into a strange community since you last saw your doctor, the author says, get acquainted with a physician while you and your family are all well. A letter to your last doctor, a nearby hospital or the local medical society will give you the names of two or three good physicians.

Then call one of them to your home to meet your family. When the need arises, often so unexpectedly, he knows with whom he is dealing and thus is immeasurably better equipped to meet any situation with a quick and accurate definition of the best plan of battle.

Do not measure age by the years that have flown, or yet by the mirror; it, too, may deceive. Measure it by the present condition of the human machine, by estimating the reserve stock of health, vitality and the apparent life-enjoying capacity remaining.

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† A digest of the minutes of the business sessions will appear in the February issue of California and Western Medicine.

* President Sawyer's address appears in this issue of California and Western Medicine, on page 20.

MISCELLANY

Under this department are ordinarily grouped: News Items; Letters; Special Articles; Twenty-five Years Ago column; California Board of Medical Examiners; and other columns as occasion may warrant. Items for the News column must be furnished by the fifteenth of the preceding month. For Book Reviews, see index on the front cover, under Miscellany.

NEWS

Coming Meetings

American Medical Association, St. Louis, Missouri, May 15 to 19, 1939. Olin West, M.D., Secretary, 535 North Dearborn Street, Chicago, Illinois.

California Medical Association, Hotel Del Monte, May 1 to 4, 1939. George H. Kress, M.D., Secretary, 450 Sutter Street, San Francisco.

* * *

Western Section, American Laryngological, Rhinological, and Otological Society, Spokane, Washington, January 29, 1939. Frederic G. Sprowl, M. D., Medical Arts Building, Spokane, Washington, Chairman.

Medical Broadcasts*

Los Angeles County Medical Association

The radio broadcast program for the Los Angeles County Medical Association for the month of January is as follows:

Thursday, January 5—KECA, 10:45 a. m., The Road of Health.
Saturday, January 7—KFI, 9:00 a. m., The Road of Health; KFAC, 11:30 a. m., Your Doctor and You.
Thursday, January 12—KECA, 10:45 a. m., The Road of Health.
Saturday, January 14—KFI, 8:00 a. m., The Road of Health; KFAC, 11:30 a. m., Your Doctor and You.
Thursday, January 19—KECA, 10:45 a. m., The Road of Health.
Saturday, January 21—KFI, 9:00 a. m., The Road of Health; KFAC, 11:30 a. m., Your Doctor and You.
Thursday, January 26—KECA, 10:45 a. m., The Road of Health.
Saturday, January 28—KFI, 9:00 a. m., The Road of Health; KFAC, 11:30 a. m., Your Doctor and You.

Health of the Nation.—The United States Public Health Service has announced that influenza made its seasonal rise during the four-week period ending October 8. The increase was about 35 per cent over the number of cases reported during the corresponding period of last year. The increased prevalence was noted particularly in the South Atlantic and South Central areas.

Smallpox has taken a decided drop, the current incidence being about 70 per cent of that for 1937.

Epidemic poliomyelitis was at the lowest stage recorded for any similar period during the last decade.

Meningococcus meningitis shows the lowest incidence reports for the past ten years.

Typhoid fever was also at the lowest point recorded during recent years.

Diphtheria showed a rise of about 20 per cent, but the disease is low compared with average incidence for the years 1933–1937.

Scarlet fever showed a normal increase.

There is every indication that the year 1938 will record the best public health conditions that have ever been established in the United States.

Error in Reprint Order.—Through an oversight, an order for reprints of an article, "Vitamin D in Acne," which appeared in California and Western Medicine in its issue of August, 1938, on page 127, was permitted to go to the printers without first securing the approval of the author, Merlin T.-R. Maynard, M. D., of San Jose. The reprints were later sent out by a pharmaceutical house, to the embarrassment of Doctor Maynard, to whom our regrets are expressed for the error.

Pacific Coast Society of Obstetrics and Gynecology. Dr. Alice Maxwell, member of the staff of the University of California Medical Center, has been named president-elect of the Pacific Coast Society of Obstetrics and Gynecology, the first woman to ever hold this position. The annual meeting of the society was held recently in Los Angeles.

Doctor Maxwell has been associate professor of obstetrics and gynecology for the past several years. She was graduated from the University at Berkeley in 1912, and three years later obtained her M.D. degree from the University's medical school. She has been a member of the medical school faculty since her graduation, and is now an acknowledged leader in her field.

The society to which Doctor Maxwell has been named the president apparent, includes obstetricians and gynecologists in Washington, Oregon and California, and has been established for seven years.

Lawrence Briefs Properties of Neutron Ray.—The formal introduction of a new and potentially powerful form of radiation into the field of medicine, to stand beside the x-ray and radium, is described by Dr. John H. Lawrence of the University of California Medical School in the Handbook of Physical Therapy of the American Medical Association, Chicago. The new radiation is provided by the neutron ray, a product of the University's cyclotron in Berkeley. Preliminary tests of the ray are now being made on human patients.

"For the first time the biologist and the physician have a penetrating form of radiation which behaves differently from any known quality of x-rays in its biologic effect," Doctor Lawrence said. "Whether the neutron ray will be relatively more destructive on one or more neoplasms (tumors) clinically, and will be a valuable aid in the therapy of neoplastic disease, only future work will tell.

"Modern developments in physics led to the induction of radio-activity in nearly all the elements and the production of a new form of biologically active and penetrating radiation—the neutron ray."

The radio-active substances produced by the cyclotron in addition to the neutron ray, and also found useful in different types of therapy, are likewise described by Doctor Lawrence in the article:

"Radio-active elements are 'tagged' atoms, but chemically they resemble their inactive relatives. Hence, study of their distribution after injection, by means of an electroscope or a Geiger counter, gives fundamental information concerning the metabolism of the various elements. Furthermore, a new method of comparing normal and disease processes is made possible. The selective deposition of elements in tissues (phosphorus in bone, iodin in the thyroid) introduces a new method of selective irradiation and offers possibilities in therapy."

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* County societies giving medical broadcasts are requested to send information as soon as arranged (stating station, day, date and hour, and subject) to California and Western Medicine, 450 Sutter Street, San Francisco, for inclusion in this column.

Pacific States Medical Executives' Conference.—A Western Medical Association, to serve as an advisory and study group for physicians in eight western states, was being formed in Portland, Oregon, on December 4, according to a United Press dispatch.

The organization, which is to represent Oregon, Utah, Washington, California, Nevada, Arizona, Idaho, and Wyoming medical associations, will iron out problems of prepaid medical fees and preventive medicine, the dispatch said.—Salt Lake City *Telegram*, December 7, 1938.

Venereal Disease Control Program.—Discussion of the venereal disease control program of the United States Public Health Service and possible action on new projects including studies of opium and quinine derivatives and the production and use of yellow fever vaccine featured the semi-annual meeting of the National Advisory Health Council at the National Institute of Health.

Dr. R. A. Vonderlehr, Assistant Surgeon-General in charge of the Division of Venereal Diseases of the United States Public Health Service, presented the Government's program for the control of venereal disease and comment on the progress which is being made in the various states with federal grants-in-aid.

The proposals regarding chemotherapy (studies centering around the opium and quinin derivatives) and the extension of virus diseases research to include laboratory studies of the production and use of yellow fever vaccine were presented by Dr. L. R. Thompson, Director of the National Institute of Health.

Members of the Council considered also a number of suggested coöperative studies to be carried on jointly by the National Institute of Health and scientists from various universities and research organizations.

Reports on the leprosy investigations in various parts of continental United States and in Honolulu, Hawaii, were presented, and discussion centered around the importance of such studies and the extent to which research should be carried on in the future.

Dr. Clifford E. Waller, Assistant Surgeon-General in charge of the Domestic Quarantine Division of the Public Health Service, presented for the consideration of the Council the proposed National Health Program, which includes an extension of public health facilities and improvements in medical care and hospitalization opportunities for people in all parts of the country, especially in those rural areas where the need is greatest.

The Council's attention was directed to the Hagerstown studies of health among children of school age, which are being directed by Dr. Thomas B. McKneely; and to the tuberculosis studies which are now in progress in Tennessee and Louisiana.

Dr. Thomas Parran, Surgeon-General of the United States Public Health Service, presided at the meeting, which was attended by the following members of the Advisory Council: Dr. Roger Adams, Department of Chemistry, University of Illinois, Urbana, Illinois; Dr. Eugene L. Bishop, Associate Professor of Preventive Medicine, Vanderbilt University, Nashville, Tennessee; Dr. Lowell J. Reed, Dean, School of Hygiene and Public Health, Johns Hopkins University, Baltimore, Maryland; Dr. Ernest R. Gentry, Lieutenant Colonel (M.C.) United States Army, Washington, D. C.; Dr. Waller S. Leathers, Dean, Vanderbilt University School of Medicine, Nashville, Tennessee; Dr. Roger I. Lee, practicing physician, Boston, Massachusetts; Dr. Esmond R. Long, Director, The Henry Phipps Institute, Philadelphia, Pennsylvania.

Dr. Karl Fredrich Meyer, Director, Hooper Foundation for Medical Research, University of California; Dr. John R. Mohler, Chief, Bureau of Animal Industry, Department of Agriculture, Washington, D. C.; Dr. Milton J. Rosenau, Professor of Public Health, University of North Carolina, Chapel Hill, North Carolina; Dr. Wilbur A. Sawyer, Director, International Health Division, Rockefeller Foundation, New York, New York; Dr. Alfred Stengel, Professor, Medicine, University of Pennsylvania, Philadelphia, Pennsylvania; and Dr. Charles S. Stephenson, Commander (M.C.) U. S. Navy, Washington, D. C.

Los Angeles Surgical Society.—The annual meeting of the Los Angeles Surgical Society was held on Friday and Saturday, December 9 and 10, 1938, with Dr. Owen H. Wangensteen of Minneapolis, Minnesota, as the guest speaker.

The program follows:

FRIDAY, DECEMBER 9

9 a. m.

Dry Surgical Clinic, Los Angeles County General Hospital
Owen H. Wangensteen
Pitfalls in Abdominal Surgery, Verne C. Hunt

12:30 p. m.

Luncheon—County Medical Building
1925 Wilshire Boulevard

2 p. m.

Gastrectomy and Gastro Duodenal Ulcers, E. C. Moore.
Mesenteric Thrombosis, Case Report, Charles W. Reeder.
Primary Hydatid Cyst of the Pleura, E. Vincent Askey.
Intraductal Papilloma and Carcinoma of the Breast, John W. Budd (by invitation).
The Status of Surgery in Angina Pectoris, Rupert B. Raney.
Repair of Laceration of Facial Nerves, Case Reports, Pierre Viole.
Vesico-Intestinal Fistula, Report of Case, Carl W. Rusche.

Recess, Ten Minutes

Carcinoma of the Thyroid, Case Report, C. T. Sturgeon.
Gas Bacillus Infection of the Abdominal Wall in Appendicitis, Case Report, Frank J. Breslin.
Sinus and So-Called Functional Nervous Disorders, F. M. Turnbull.
Intervertebral Disc Abscess Simulating Ruptured Nucleus Pulposus, G. H. Patterson.
Delayed Rupture of the Spleen, William H. Olds.
Bone Metastasis Following Carcinoma of the Breast, A. E. Gallant.
Surgical Drainage, Special Application of the Suction Principle, Rafe C. Chaffin.

Annual Formal Dinner—7 p. m.
California Club

SATURDAY, DECEMBER 10

9 a. m.

Dry Surgical Clinic, Los Angeles County General Hospital
Owen H. Wangensteen
Traumatic Diaphragmatic Hernia, with Motion Pictures, H. E. Schiffbauer

12:30 p. m.

Luncheon—County Medical Building
1925 Wilshire Boulevard

2 p. m.

Intussusception of the Ureter, H. C. Bumpus, Jr.
Intraperitoneal Rupture of the Urinary Bladder, Case Report, J. Norman O'Neill.
Physiological Changes in the Leucocyte Count, A. H. Foord (by invitation).
Liver Abscess with Perforation, E. C. Pallette.
Spindle Cell Carcinoma of the Thyroid, W. P. Kroger.
Malignant Melanoma of the Breast with Seven Year Follow-up, H. K. Bonn.
Traumatic Rupture of the Urethra, Case Reports, A. J. Scholl.

Ten-Minute Recess

Mortality in Obstructive Resection of the Colon, Clarence J. Berne.
Exophthalmic Goiter with Arterial Gangrene, Case Report, Harlan Shoemaker.
The Significance of Rectal Bleeding, Kenneth Smiley.
Granulomatous Infections of the Bone, Paul E. McMaster.
Familial Dermoid Cysts, Case Report, W. H. Brownfield.
Case of Right Para-Duodenal Hernia: Operation, Recovery, Donald Collins.
Mortality of Acute Perforation of Peptic Ulcer, Harold L. Thompson.

Formal Dinner Dance—7 p. m.
Wilshire Country Club

Fewer Deaths in California in 1938.—Records for the first six months of the present year indicate that the California general mortality rate for 1938 will be one of the lowest on record. Almost 5,000 fewer deaths were registered during the first half of 1938, as compared with the first half of 1937. The reduction is quite evenly distributed, all but ten counties of the state having contributed reduced numbers of deaths during the period studied. In Los Angeles County alone there were almost 2,000 fewer deaths during the first six months of this year, and in San Francisco there were 618 fewer deaths registered. In those interior counties of California, where migratory laborers have settled in large numbers, fewer deaths were recorded during the first half of 1938 than in the first half of 1937.

It would appear that this reduction is due, in part at least, to the absence of influenza in California during the early part of the calendar year. In 1937 influenza was widely prevalent and many deaths occurred during the early part of the year.

It would seem, however, that the population of this state is increasing rapidly. The increase in births is more than 11 per cent and the decrease in deaths is 12.5 per cent and the migration to California is extensive. If the present trend continues, the official United States census to be taken in 1940 will reveal a tremendous growth in the population of this state.

Following are the numbers of deaths registered in California counties during the first half of 1937 and 1938:

DEATHS
BY COUNTIES

County	Jan. to June, Inc.	
	1938	1937
Alameda	3,090	3,176
Alpine	......	......
Amador	39	50
Butte	295	326
Calaveras	47	63
Colusa	74	82
Contra Costa	348	438
Del Norte	28	32
El Dorado	62	75
Fresno	935	982
Glenn	61	57
Humboldt	290	340
Imperial	336	415
Inyo	33	41
Kern	655	717
Kings	163	222
Lake	47	74
Lassen	62	61
Los Angeles	14,551	16,545
Madera	122	135
Marin	247	283
Mariposa	15	24
Mendocino	230	286
Merced	227	248
Modoc	43	36
Mono	9	6
Monterey	318	343
Napa	343	408
Nevada	118	129
Orange	793	750
Placer	207	221
Plumas	52	79
Riverside	570	643
Sacramento	1,002	1,178
San Benito	64	67
San Bernardino	1,034	1,175
San Diego	1,583	1,773
San Francisco	4,379	4,997
San Joaquin	915	1,141
San Luis Obispo	218	204
San Mateo	448	529
Santa Barbara	429	461
Santa Clara	1,170	1,275
Santa Cruz	311	304
Shasta	118	152
Sierra	19	11
Siskiyou	160	144
Solano	182	262
Sonoma	455	541
Stanislaus	364	397
Sutter	84	106
Tehama	104	102
Trinity	29	23
Tulare	470	533
Tuolumne	84	92
Ventura	285	383
Yolo	167	177
Yuba	108	153
Totals	38,592	43,467

Conference of Hospital Administrators in Seattle, February 19 to 23, 1939.—Administrators of 1,350 hospitals, located in the ten Western States, British Columbia, Alaska, and Hawaii, have been invited to Seattle, February 19 to 23, to study and discuss the colossal problem of health care.

With the nation agog over health and hospital insurance, socialized and subsidized medicine and hospitalization, with the next Congress preparing to act upon a national health program affecting every citizen and his family, the Seattle meeting promises unusual and timely interest.

The meeting is the thirteenth annual convention of the Association of Western Hospitals, allied with which the Western Conference, Catholic Hospital Association, the Washington, Oregon, and California state hospital associations, and the American College of Hospital Administrators will be in session.

"The Part of the Hospital in this Growing Program of Health Care," the convention theme, will be approached from every angle of consideration, and many eminent hospital authorities and medical doctors will discuss its phases.

At the same time, taking advantage of the assemblage of hospital and medical men from this wide area, most leading makers and distributors of hospital and clinical apparatus and equipment for treating disease, maladjustments and fractures, will display exhibits in a miniature hospital world's fair.

"Guard Against Syphilis."—"Guard Against Syphilis" is the slogan of National Social Hygiene Day to be observed throughout America on February 1. The day will be marked by some 5,000 meetings to highlight present community campaigns against syphilis and will focus public attention on vital next steps in the conquest of syphilis, according to Dr. Walter Clarke, executive director of the American Social Hygiene Association.

Evidences of interest in the forthcoming event, the third annual observance in the current attack on syphilis, point to a larger nation-wide demonstration than those of previous years, Doctor Clarke said. The Association's offices in New York as well as San Francisco report increased activity and interest on the part of official and voluntary health and welfare agencies, civic groups, service clubs, women's organizations, churches, schools, and upward of one thousand youth bodies.

Defining the objectives of the 1939 attack in terms of the slogan, these points were said to underly present national, state-wide and community planning in social hygiene:

Guard against syphilis by telling the American people about this dangerous disease—how it can be prevented and cured.

Guard against syphilis in youth, the age of greatest incidence, by strengthening the efforts of church, home, and school to provide better facilities for sex education, character development, and preparation for marriage; and by correcting community conditions which threaten the health and welfare of young people.

Guard against syphilis in marriage and childhood by encouraging good laws—and their observance—requiring examinations for all those about to marry and for all expectant mothers.

Guard against syphilis by attacking prostitution and quackery, two arch-accomplices of the disease.

Guard against syphilis by supporting adequate voluntary and official health programs, both state and local.

As in years past, press and radio aid will be sought in cultivating public interest in Social Hygiene Day and its objectives. The American Social Hygiene Association, 50 West Fiftieth Street, New York, is offering posters, envelope enclosures, a special tabloid newspaper for free mass distribution, and a complete kit of publicity and program aids for program planners.

The United States Public Health Service is again cooperating.

American Board of Obstetrics and Gynecology.—The general oral, clinical, and pathological examinations for all candidates, Part II Examinations (Groups A and B), will be conducted by the entire Board, meeting in St. Louis, Missouri, on May 15 and 16, 1939, immediately prior to the annual meeting of the American Medical Association. Notice of time and place of these examinations will be forwarded to all candidates well in advance of the examination dates.

Candidates for reëxamination must request such reëxamination by writing the secretary's office before the following dates: Part I—January 1, 1939; Part II—April 1, 1939. Candidates who are required to take reëxaminations must do so before the expiration of three years from the date of their first examination.

Application for admission to Group A, May, 1939, examinations must be on file in the secretary's office by March 15, 1939.

Application blanks and booklets of information may be obtained from Dr. Paul Titus, Secretary, 1015 Highland Building, Pittsburgh (6), Pennsylvania.

National Advisory Cancer Council. — Dr. James B. Murphy, Chief of the Cancer Research Division of the Rockefeller Institute, New York, and Dr. Mont Rogers Reid, Director of Surgical Service of the Cincinnati General Hospital and Professor of Surgery at the University of Cincinnati, were recently named as new members of the National Advisory Cancer Council for three-year terms.

The appointments were announced by Surgeon-General Thomas Parran of the United States Public Health Service, who is ex-officio chairman of the Cancer Council. The new members of the Council succeed Dr. Francis Carter Wood, Director of the Crocker Institute of Cancer Research, Columbia University, and Dr. James Ewing, Director of the Memorial Hospital, New York, both of whom were named as original members of the Council on October 16, 1937.

Continuing members of the Cancer Council are President James B. Conant of Harvard University, who is an authority on chemistry; Dr. Arthur H. Compton of the University of Chicago, a Nobel prize-winner in physics; Dr. C. C. Little, Managing Director of the American Society for the Control of Cancer; and Dr. Ludvig Hektoen of Chicago, former director of the John McCormick Institute for Infectious Diseases, who is serving as executive director of the National Advisory Cancer Council.

The Cancer Council shares with the Surgeon-General responsibility for the policies and activities of the National Cancer Institute Act, with particular regard to grants-in-aid.

"The National Cancer Institute Act is a new type of Government service for all the people," Surgeon-General Parran declared in commenting on appointments to the Council. "Through it the Government is able to offer concrete help, not only to the official agency, but also to the private scientific institution, or the accredited individual, in order to speed progress toward a scientific goal."

The stakes of victory against cancer are so high and the hope of every American family in that victory is so pathetically earnest, in the opinion of the Surgeon-General, that every effort must be made to close in on this enemy of mankind.

"The work of the National Cancer Institute is a test of the capacity of Government to lead through service. I believe that the results to date are showing additional evidence of the capacity of men of science to work together and profitably for the solution of their great common problems. In the Institute we have a new vantage point and a new hope of success for our attack on cancer," Surgeon-General Parran concluded.

Medical Vacancies in California.—There is a scarcity of medical men in California, so that is why the State Personnel Board let down the bars of residence requirements today as it sought to qualify some eighty professional men.

Instead of having resided in the state for one year, any man in the United States may take the examinations to be held on January 5, it was announced by Louis J. Kroeger, executive officer of the Board.

The state is seeking to qualify fifteen physicians and internists, ten eye, ear, nose and throat physicians, and twenty-five junior physicians.

Salaries ranged from $100 to $200, plus maintenance.—Pittsburgh *Post-Dispatch*, December 5, 1938.

California Leaders to Map Paralysis Drive.—With Joseph M. Schenck, Vice-President of the National Foundation for Infantile Paralysis and General Chairman for California, presiding, four hundred leaders in Southern California civic affairs recently assembled at the Biltmore Hotel for a luncheon at which plans were formulated for the infantile paralysis drive which starts in January.

Adding significance to the occasion will be the presence of several Northern California drive leaders, including Attorney-General-Elect Earl Warren, Chairman for Northern California; Mayor Angelo Rossi of San Francisco, Chairman for San Francisco, and George Baker, San Francisco director of organization.

Speakers will include Al Jolson, master of ceremonies; Mayor Fletcher Bowron, Louis B. Mayer, and Governor-Elect Culbert D. Olson. Also taking a prominent part in the plans will be Southern California drive leaders, headed by Joseph Scott, Southern California chairman; Sheriff Eugene Biscailuz, Los Angeles County chairman, and Prentiss Moore, Los Angeles City chairman.

Official announcement will be made at the luncheon of the new plan whereby 50 per cent of all funds raised by each community will remain in the community for local relief distribution.

The Advisory Committee for the drive includes Norman Chandler, Dr. Harlan G. Shoemaker, Victor H. Rossetti, Mrs. James K. Lytle, and the Right Rev. W. Bertrand Stevens, Episcopal Bishop of Los Angeles.

American Board of Ophthalmology.—The American Board of Ophthalmology announces an important change in its method of examination of candidates for the Board's certificate.

Examinations will be divided into two parts. Candidates whose applications are accepted will be required to pass a written examination which will be held simultaneously in various cities throughout the country approximately sixty days prior to the date of the oral examination.

The written examination will include all of the subjects previously covered by the practical and oral examinations.

Oral examinations will be held at the time and place of the meeting of the American Medical Association and of the American Academy of Ophthalmology and Otolaryngology, and occasionally in connection with other important medical meetings. The oral examination will be on the following subjects: external diseases; ophthalmoscopy; pathology; refraction; ocular motility; practical surgery.

Only those candidates who pass the written examination and who have presented satisfactory case reports will be permitted to appear for the oral examination.

Examinations scheduled for 1939—Written: March 15 and August 5. Oral: St. Louis, May 15; Chicago, October 6.

Applications for permission to take the written examination on March 15 must be filed with the secretary not later than February 15.

Application forms and detailed information should be secured at once from Dr. John Green, Secretary, 6830 Waterman Avenue, St. Louis, Missouri.

M. D. License Plates.—After January 1, New York State physicians will no longer need distinguish their cars by special insignia. Police and public alike will instantly be able to spot those devoted to medical duty by their license plates.

At the request of the State Medical Society, the Department of Motor Vehicles will make available ten thousand of these standard designations for the use of automobiling doctors. Replacing the ordinary plates, they substitute "M. D." for identifying letters; are numbered from one to 9,999. They entail no other cost than the usual license fee.

The plates are available only to active practitioners. Each applicant for them must be certified by a county medical society, whether he is a member or not.

Life Insurance Policies.—There are sixty-four million Americans wise enough to carry life insurance for the benefit of themselves or their dependents.

These policies average $1,725 each, showing that millions of small amounts are carried, as well as the immense sums for which the comparative few are insured.

These facts were reported at the convention of the Association of Life Insurance Presidents in New York recently.

This year, said Julian Price, Chairman of the Association, policyholders and beneficiaries will receive about $2,600,000,000 from the companies—$975,000,000 in death claims and the remaining $1,635,000,000 to living policyholders as matured investments, annuities, surrendered values, policy dividends, and disability payments.

By the end of the year it is estimated that the amount of life insurance in force will amount to the stupendous sum of $11,300,000,000—the largest amount in history.

That so many Americans are insured, and for so much, is a notable exercise of common sense on their part.

Stillbirths in California.—There has been a fairly consistent downward trend in stillbirths during recent years in California. In 1937 there were 2,130 stillbirths recorded, giving a rate of 22.6, which is the lowest stillbirth rate ever recorded in California. In 1936 there were 1,997 stillbirths recorded, giving a rate of 23.6 per 1,000 total births. In 1920 there were 2,059 stillbirths recorded, with a rate of 30.6.

The following table gives the number of stillbirths, together with rates from 1920 through 1937:

Year	Total Births	Stillbirths	Rate Per 1,000 Live Births
1920	69,257	2,059	30.6
1921	74,642	2,204	30.4
1922	75,541	2,220	30.3
1923	82,634	2,397	29.8
1924	89,488	2,589	29.8
1925	87,667	2,175	25.4
1926	84,690	2,318	28.1
1927	86,533	2,219	26.3
1928	86,063	2,420	28.9
1929	83,881	2,383	29.2
1930	86,809	2,427	28.7
1931	83,885	2,332	28.6
1932	80,261	2,153	27.6
1933	77,261	2,032	27.0
1934	80,316	1,874	23.9
1935	82,188	1,966	24.5
1936	86,457	1,997	23.6
1937	96,416	2,130	22.6

Although 88.8 per cent of the population of California, in 1930, consisted of members of the white race, they contribute a smaller proportion of both births and stillbirths. Mexicans, who, in 1930, constituted 6.4 per cent of the population, contribute almost 15 per cent of the births and 19 per cent of the stillbirths.

More stillbirths are recorded among males. During recent years, the average of males to females born alive is 105 to 100, but there are 128 males stillborn to each 100 females. While it is possible that some of these ratios may be changed, there is sufficient evidence to state that the ratio of males to females in California is higher among stillborn infants than among infants born alive.

Third International Cancer Congress.—This Congress will be held under the auspices of the International Union Against Cancer, in Hadden Hall Hotel, Atlantic City, New Jersey, on September 11 to 16, 1939.

Membership in the Congress is secured by application to the secretary-treasurer, with remittance of $15. Make checks payable to the Third International Cancer Congress and mail to Dr. Donald S. Childs, 713 East Genesee Street, Syracuse, New York.

Membership in the Congress does not include the right to present a paper unless the paper or an abstract has been submitted to and been approved by the Program Committee. All papers must be read in person by the author. In no case will a paper be accepted without an abstract. The Program Committee reserves the right to reject any paper without recourse. All papers and abstracts, as well as any questions pertaining to them, should be addressed to Professor Francis Carter Wood, President, Third International Cancer Congress, 630 West 168th Street, New York, N. Y.

Projection will be provided for lantern slides in the standard sizes, such as American 3¼ by 4 inches, English 3¼ by 4¼ inches, and Continental 8½ by 8½ or 9 by 12 centimeters. Facilities for the projection of 16 and 35 millimeters film will also be available. Projectoscopes for showing full size roentgenograms will be provided by the firms of Carl Zeiss and E. Leitz.

The proposed sections are as follows: General research; biophysics; genetics, general pathology of cancer; surgery; radiological diagnosis; radiotherapy; statistics; and education. Further details concerning section chairmen, committees, etc., will be announced later.

Experiments Show Hemorrhages Due to Calcium Lack.—The first recorded correlation of certain types of paralysis in animals to a calcium-deficient diet, is reported by the department of biochemistry of the University of California. The paralysis is of hemorrhagic origin, possibly akin to certain brain hemorrhages in man.

It has been known for some time that, with a low blood calcium, human subjects and many animal species develop the convulsive condition known as tetany. The more profound and complex condition of paralysis, however, has not been attributed to a deficiency of calcium heretofore, despite the fact that it has been observed often in nature, among browsing animals.

Nutritional surveys have shown that calcium is the most common deficiency in the American diet, and, as a result, scientists have concentrated on the study of this element for the past twenty years. It is most readily supplied by eggs, beans, milk, cheese, almonds, and a number of other food products.

The authors of the study observed that a profound neurological disturbance develops in growing rats maintained on diets very low in calcium, which had heretofore not been associated with a deficiency of calcium. The neurological picture, which is quite complex, is suggestive of a diffuse lesion involving the cortex, basal ganglia, spinal cord, and peripheral nerves. When the injury was not too advanced, recovery was hastened by feeding the animals a control diet.

The study was made by Dr. David M. Greenberg, Associate Professor of Biochemistry, Muriel D. D. Boelter, graduate student in biochemistry, and Dr. Benjamin W. Knopf, a physician. A report is to appear in the magazine *Science,* the official organ of the American Association for the Advancement of Science.

Better Education of Drivers and Road Etiquette at Base of Accident Prevention.—Universal adoption of a road etiquette that has in it certain well-justified taboos will probably do more to avert highway accidents than any means now being employed, Dr. Ray Lyman Wilbur, President of Stanford University, advises the California Safety Council.

In a safety message to President Fred D. Parr of the state-wide accident prevention agency, Doctor Wilbur, himself a Safety Council director, says:

"The history of mechanical contrivances in industry and in transportation is that they have always at the beginning had a high accident rate. With the application of safety devices and the education of employees, marked reductions in such accidents have been the rule. In connection with the high speeds possible with modern automobiles and modern roads there have been improvements in the brakes, in the steering devices, and in the durability of all parts of the automobile.

"There can still be marked improvements in the roads in the illumination of all highways, in automobile lights, signs, etc.; Doctor Wilbur continued, "but all of these will be futile unless the drivers can be trained. With a new crop of drivers each year, and with increasing consumption of alcohol, a continuation of the accident problem is inevitable. I think that we must attack every weakness, but particularly educate the drivers in the dangers involved. Also we must develop an etiquette of the road which will be universally accepted.

"Taboos have controlled human conduct for untold centuries. If we can get a road etiquette established that has in it certain well-justified taboos, I believe we can increase the safety of our highways materially."

Pneumonia Exhibit at Golden Gate International Exposition.—While men and women throughout the world celebrated another anniversary of a war armistice, scientists revealed completion of a brilliant "medical armistice" against pneumonia.

From officials of the Golden Gate International Exposition, announcement came that a New York laboratory has finally completed preparation of tested, effective antiserums for each one of the thirty-two types of pneumonia germs. The almost miraculous curative serums will be distributed this month to strategically placed depots throughout the United States.

San Francisco has been selected as one of these distributing centers.

The first public demonstration of the thirty-two antipneumonia serums will be made to the public next year in an exhibit sponsored by the Lederle Laboratories of New York for the San Francisco Fair's Hall of Science. This was reported by Dr. Milton Silverman, Director of the Hall of Science, following receipt of plans for the Lederle display.

"For centuries," Doctor Silverman said, "pneumonia has consistently ranked among the top four killers. Until only a few years ago, this terrible infection baffled scientists and physicians who attempted to find some curative method.

"Only recently, laboratories gave us the first hope that a serum might be able to battle pneumonia. The hope was pretty slim, since there are known to be at least thirty-two types of pneumonia germs, and each type requires a specific anti-serum."

In the last few months, it was pointed out, these specific anti-serums were developed for four types of pneumonia microbes, then seven, then eleven, and now, for all thirty-two.

It is expected development and proper distribution of the curative agents will cut pneumonia mortality down to nearly the vanishing point.

"Proper usage of the serums," Doctor Silverman emphasized, "depends almost entirely on coöperation between the physician and the patient. The longer the patient delays calling his physician the less the efficacy of the serum."

Other features to be presented in the Lederle exhibit next year include a demonstration of the cause, spread, diagnosis, and treatment of pneumonia, and a demonstration of the methods used to determine the type of a pneumonia infection and to select the proper serum.

Seek Law to Bar Epileptic Drivers from Highways. The state of California, through its Department of Public Health, is to inaugurate legal action to forbid the operation of motor vehicles by persons suffering from epilepsy, in an attempt to cut down the numerous accidents caused by physically unfit drivers. This was announced recently by Dr. Walter M. Dickie, Director of the Department, in a communication to the University of California Medical Center. According to Doctor Dickie, the legislation will be presented at the next session of the Legislature.

Under the present law it is not possible for any hospital or private physician to report cases of epilepsy to the department, although both are known to be receiving numerous complaints about epileptic drivers. According to a number of medical authorities, the epileptic in many cases is not aware of his condition. Cases have been known where the epileptic driver lapsed into unconsciousness at the wheel of a car, caused an accident thereby, and then recovered his senses without having been in any way aware of the lapse. It has thus been impossible to place responsibility for a number of accidents.

According to Doctor Dickie it is the plan of the department to have the reported cases submitted to the State Division of Motor Vehicles so that the division may have opportunity to keep a constant check on epileptic drivers. There is no intention on the part of the department to keep epileptics out of automobiles, he said, as such recreation may be beneficial to them. The only intent is to keep them from driving motor vehicles while suffering from their complaint.

Present motor-vehicle regulations provide that the applicant for a license must state whether he is suffering from a physical disability of any kind. But many epileptics either evade this or attribute their disorder to indigestion or other complaint in a nondisabling class, officials of the division say. There is no way to compel a correct answer, and some other means must be found for the state to meet the situation.

Initiative Costs in November Election Told.—Sacramento, December 9.—Nearly $1,000,000 was spent during the August primary and November general election campaigns in support and opposition to the twenty-five propositions appearing on the ballot, according to statements filed today with Frank C. Jordan, Secretary of State.

The exact amount expended was $945,063, with only a few small statements outstanding, Jordan reported.

Opponents to the Labor Initiative No. 1 on the November ballot spent $100,000, and organizations supporting the defeated measure expended more than $300,000, Secretary of State Jordan reported. . . .

Proposition No. 2

Chief expenditures against No. 2, the Humane Pound Act, were: B. C. Raulston, M.D., and George D. Maner, M.D., Los Angeles, $5,314; California Medical Association, $14,423; California Society for Promotion of Medical Research, $29,545. Favoring the Act were the California Citizens' Committee, $3,189; California Committee. $12,077. The Act was defeated.

Press Clippings.—Some news items from the daily press, on matters related to medical practice, follow:

Another Medical Initiative

Free Hospitals Sought

Creation of a state commission of nine members to control services in all state hospitals and physicians using them so the public can use them without charge is proposed in an initiative measure the Attorney General's office at Sacramento was yesterday asked to title.

Avery C. Moore of Berkeley, its sponsor, described it as a step extending "to the people of California the benefits of medical science along the same lines as educational benefits now being enjoyed."

Approval of the measure by the voters would entail an amendment to the state constitution and, in the event that should be forthcoming, Moore hopes to have the plan extended to private hospitals and physicians and service in private practice.

The manner of financing the suggestion was made that costs be budgeted by the Governor after a year's trial established actualities and estimates.

The commission, under the proposal, would have the power of regulation over all physicians, surgeons, osteopaths, chiropractors, and registered nurses.*

As soon as word of the proposal reached the Capitol, state officials expressed the conviction that it is entirely impracticable and can be expected to bring opposition generally from the medical profession.

Harry Lutgens, director of state institutions, said the seven state hospitals now are crowded to their capacity of 22,000 patients and have no room for more. He declared patients now pay an average of $20 monthly for treatment, which means an income to the state's general fund of about $4,000,000. The cost of maintaining the institutions, however, is $14,000,000 biennially, he said.

Dr. C. B. Pinkham, secretary of the State Medical Board, predicted "vigorous" opposition on the part of the medical profession.—San Francisco *Chronicle*, December 29, 1938.

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Health and Pension Laws in Making

Two New Campaigns Begin for Social Legislation—Behind the Health and Social Security Reports—The Plans Congress Will Consider

The Government is moving forward on two fronts to extend social legislation.

More adequate health services and bigger and better social security are the two goals at which the Administration is now shooting.

The health program, which shortly will be presented to Congress in the form of an interdepartmental report, was drafted by a committee headed by Miss Josephine Roche and at the behest of President Roosevelt.

The proposed health program would do two things: Provide adequate medical care for those who cannot pay for it; and make medical services less expensive for those who can afford to pay a modest fee.

Cost of Free Care for the Indigent

To accomplish the first objective—free care for indigent persons—Miss Roche's Interdepartmental Committee report recommends that State and Federal governments embark on a ten-year joint program to cost the Federal Government $65,000,000 the first year and up to a maximum of $850,000,000 a year. Maternal and child care, better public health services and hospital facilities would be provided.

Simultaneously, the Government is urged to back voluntary health insurance plans. That the executive branch of the Government will not need to be urged very hard can be seen in the vigor with which the Department of Justice is pressing in a District of Columbia court charges of violation of the Sherman Antitrust Law against the American Medical Association, the Medical Society of the District of Columbia, other medical societies, and twenty-one prominent physicians. A grand jury has just indicted the societies and physicians, basing the indictment on alleged discrimination by the defendants against Group Health Association, Inc., a medical coöperative of Government workers. . . .

Extending Coverage of Social Security

Their report urges speeding up and increasing of old-age payments, broadening the act to cover 14,800,000 persons not included in the forty-two million who now are covered, and abolishing the $47,000,000,000 reserve fund. Widows and young children of annuitants, farm and domestic workers would be some of the new groups entitled to receive payments.

To pay the bigger bill, the Government would be asked to contribute one-third of the cost. The price of this expanded social insurance plan would be expected to absorb 10 to 12 per cent of national income in 1980.

If translated into law, these two new Government campaigns for social improvements may mean benefits to four of every ten persons in the country.—The United States *News*, December 27, 1938.

Illness Costs British Over Billion Yearly

London, December 3.—(UP)—Illness costs Great Britain about $1,415,000,000 a year.

Of this sum $250,000,000 goes to the doctors. There are about 17,500,000 person under the National Health Insurance plan, and their average time on the sick list is a fortnight a year. Treatments and maintenance costs account for the rest.

The nation spends $585,000,000 annually to prevent illness.—Seattle *Sunday Times*, December 4.

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Behind the News*

Osteopath on Health Board, Final Merriam Fillip

Swiftie: Despite everything he has been through recently, Governor Merriam has just demonstrated that he can still wind up and pitch one right past the belt-buckle. To the State Board of Health Mr. Merriam has just appointed Dr. Norman F. Sprague of Long Beach. About this there would be nothing unusual except that Doctor Sprague is an osteopath. This, so far as our men can learn, is the first time an osteopath has ever crashed the line of the M. D.'s. So various members of the medical profession are just sitting back now, waiting for the riot to start.

But, because of the Governor's skillful manipulations, a riot is exactly what may not develop. Mr. Merriam, the best information is, was paying a political debt to the osteopathic group by giving it something called an opening wedge. Yet the man he picked is perhaps the last California osteopath the doctors of medicine would select for a target. Not only has he done the extra medical study required for an osteopath to obtain a physician and surgeon license, but he has softened up the opposition by the manner in which he has helped pioneer the osteopathic ward in the Los Angeles County Hospital.

Doctor Sprague was the first, or among the first, osteopathic physicians admitted to the hospital after a thunderous battle between the two schools of practice which took place in the South several years ago. Apparently he did a very successful job there as an opening wedge—without rousing the ire of the M.D.'s. However, the sky may not remain too serene—provided the "regular" doctors can figure out something to do about it.

The appointment means a hearty chuckle through the Olson camp, because preëlection sentiment among the doctors of medicine—no mean political group—was definitely pro-Merriam. The Governor handled that situation nicely, too. He early told the medical men he was considering the appointment of an osteopath—and just let them think he was joking.

* * *

Merriam: As he steps out on this day when California has one governor for the forenoon and another for the p. m., we wish a belated happy new year to Governor Merriam. He has given us plenty to write about, for he has been preëminently a politician—and politics, like icebergs, whales, and the bottom of the ocean, are mostly under the surface. But there has been one thing about this governor of the forenoon—right or wrong, nobody could push him around. He listened to his advisers and then did as he pleased. And, although he was elected to get an entirely different sort of governor, the governor of the afternoon seems, in that regard at least, to be another piece off the same bolt. He doesn't push easy, either. A happy new year to him, too.

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Medical Corps Tests

An examination to qualify candidates for appointment as first lieutenants in the Medical Corps, regular army, will be held on March 20-24, 1939, inclusive, the War Department announced yesterday.

The examination will be open to male graduates of acceptable medical schools who have completed one year's interneship and will not be over thirty-two years of age when commissions are tendered. Medical officers throughout the country will conduct both physical and written examinations. The Adjutant General, War Department, Washington, will furnish full information and application blanks.

* * *

Compulsory Marriage Examinations Sought

Compulsory examinations before marriage and tests of prospective mothers are the objects of two measures framed for consideration at the forthcoming session of the California Legislature, according to Miss Eloise A. Hafford, executive secretary of the Southern California Society for Control of Syphilis. Sixty thousand children were born last year afflicted with syphilis, she reports from national figures.

Miss Hafford will leave tonight for Sacramento for the purpose of promoting the two measures. She will be located at the Land Hotel, where she will remain until the solons complete work on the bills. She resides at 735 North Los Robles Avenue.

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*Editor's Note.—County hospitals are supported by public funds, not from state but from county sources. Public funds raised by county taxation remain under the sole jurisdiction of county boards of supervisors, hence county hospitals remain under the sole control of county authorities. A plan for a commission to "regulate physicians" (whatever that may mean) is also something new.

* With Arthur Caylor, in the San Francisco *News*, January 2, 1939.

According to Miss Hafford, ten states already have enacted laws regulating premarital tests and fifteen legislatures will give consideration to similar measures at the coming sessions. The proposed California legislation has been given wide support, it is stated.—Pasadena *Star-News*, December 31, 1938.

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California Sterilization Law Change Urged

Sacramento, December 29—(INS).—Legislation to provide sterilization for certain inmates of California prisons was recommended in Sacramento today in the biennial report of the State Board of Prison Directors.

The recommendation was made by Dr. L. L. Stanley, chief surgeon at San Quentin, and who declared "the law in effect at the present is inoperative because of the numerous provisos it contains."

It was recommended by Doctor Stanley that legislation be enacted so prisoners may be sterilized under the following conditions:

1. Men with diseases which may have been inherited and are likely to be transmitted to descendants.
2. Feeble-mindedness in any of its various grades.
3. Perversion, or marked departure from normal mentality.—Los Angeles *Evening Herald and Express*, December 29, 1938.

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Roosevelt Revives Reorganization Bill

Washington, December 8.—(INS)—President Roosevelt's program for reorganization of the Federal Government—a major New Deal proposal which met stunning defeat in the last Congress—was brought to life today in a conference at the White House.

The President called in Louis Brownlow, Charles E. Merriam, and Luther Gulick, the three advisers whose survey formed the basis for the Administration's reorganization recommendations.

With Roosevelt, the conferees debated how reorganization proposals might best be presented to the Congress convening in January.

The conference presumably explored future strategy, with particular attention to the recent election returns. In view of important Republican gains in both branches, opposition to the program may find new recruits.

With the possibility that today's conference may convince the President that another attempt should be made to put the reorganization bill through Congress, observers on Capitol Hill foresaw a long and bitter fight.

New Cabinet Officer: Department of Public Welfare

One of the most controversial features of the original bill was the establishment of a new cabinet post—Secretary of the Department of Public Welfare, under whom all welfare agencies of the government would be grouped. WPA Administrator Harry Hopkins was talked of for this post.—San Francisco *Call-Bulletin*, December 8.

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Associated Farmers of California Act to Form National Group

Ventura, December 10.—(AP)—The Associated Farmers of the Pacific, fighting efforts to establish a closed shop on American farms, moved today toward national expansion of the organization.

A committee of farm leaders from western and midwestern states, named at the concluding session of the organization's first annual convention, will direct establishment of the enlarged unit.

Appointed to the group by Col. Walter E. Garrison of Lodi, retiring president of the Pacific group, were:

Holmes Bishop of Orange, president of the Associated Farmers of California; W. F. Schilling, Northfield, Minn.; Leo W. Lighter, Kenosha, Wis.; S. C. Arnold, Broadview, Mont., and J. C. Wilson, Phoenix, Ariz.

H. L. Shumaker of Hood River, Ore., was chosen to succeed Garrison.—San Francisco *Examiner*, December 12.

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Farm Industrialization Swells Labor Demand

Fresno, December 10.—(AP)—Omer Mills, regional economist for the Farm Security Administration, speaking at the California Conference on Migrant Education here today, said the high degree of industrialization which characterizes California agriculture largely is responsible for the demand for large numbers of agricultural laborers in this state.

"Twelve per cent of California's farmers employ 78 per cent of the labor," said Mills. "These large-scale operations create the need for a large number of workers, with the result that 60 per cent of the rural population are wage-earners employed by the big operators.

"These workers are out of a job a large part of the time, with various government agencies carrying the load between peak employment periods."

Mills declared there is a decided surplus of labor in the state. He recommended removal of a part of the surplus by employing these workers on conservation projects.

Agriculturists themselves have begun to realize the problem created by specialization, he said, and revision of the cropping pattern was discussed at a recent convention of the Associated Farmers. The need of teaching migrant workers the fundamentals of sanitation and hygiene was emphasized by Edward A. Brown, supervisor of camp inspection of the Division of Immigration and Housing.

The influx of migrants has resulted in an increase in pellegra, malaria and smallpox in California, said Dr. Ellen Stadtmuller, chief of the Bureau of Child Hygiene of the State Department of Health.—San Francisco *Examiner*, December 12.

* * *

Interference in Business Scored

Washington, December 8.—(INS)—A member of the joint antimonopoly committee, Senator King, Democrat of Utah, today declared a frank announcement by the New Deal "that it will stop interfering with business would do more to bring about recovery" than the inquiry into the nation's economic structure which the committee is conducting.

"There could be no greater contribution to revival of business," he asserted, "than an unmistakable announcement the government is not going to intervene in matters which belong to private endeavor; that it is not seeking to take industries over, but that its rôle is the one of coöperation and aid.

Fears Cited

"There is no doubt but what business men have been afraid of punitive legislation, of government entering fields that should be occupied by individuals, and afraid of burdensome taxation.

"If business could feel that government truly desires to aid in every proper way, not by bounty or gift, but by sympathetically approving those relations necessary between capital and government, you'd find, I think, the touchstone to a remarkable recovery." . . .—San Francisco *Call-Bulletin*, December 8.

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Influenza: $20,000 Given New Germ Laboratory

Pacific Coast scientists will open a new attack on influenza germs in February in a State Public Health laboratory built and supported by the Rockefeller Foundation.

Dr. Walter M. Dickie, state health director, announced the Foundation had granted $20,000 to pay for a state laboratory now being built near the University of California campus in Berkeley.

Addition of a Berkeley laboratory to another already established in Minnesota is expected to help discover what geographical differences there may be in influenza virus.

Thus far scientists have isolated at least four strains, and Doctor Dickie said studies already made indicated the virus which caused the California influenza epidemic of 1936 was different from that which affected many persons on the Atlantic Coast that winter.

Ultimate goal of the coördinated laboratories is the isolation of as many strains of the virus as possible in the hope of developing from them an immunizing substance effective against a maximum number of the varieties involved.

The virus is known to build up "antibodies" or immunizing substances in the individuals affected. These antibodies protect the person for a time against an attack by more viruses of the same strain, although not necessarily against viruses of another type.

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Animal Experimentation and Scientific Medicine Endorsed by Voters

The voters of California and Colorado, November 8, by overwhelming majorities emphatically rejected proposals made in those states to undermine the structure of scientific medicine, *The Journal of the American Medical Association* for November 19 says. In California an initiative humane pound law, so called, proposing to cripple scientific research by hampering animal experimentation, was decisively defeated. In Colorado an initiative measure proposed by a group of chiropractors, to debase the quality of medical care in the state by repealing the basic science act and by destroying other safeguards that have been erected to assure adequate and scientific medical service, was met by an avalanche of negative votes, running as high as 10 to 1 in some counties.

In Oklahoma an initiative measure that would have sanctioned practices not conducive to public welfare failed to get on the ballot, because of court action instituted by the medical profession. In Ohio a chiropractic initiative somewhat similar to the Colorado initiative died aborning, the cultist sponsors apparently becoming disheartened shortly after the proposal was submitted to the attorney-general for his approval as to form. Petitions in Ohio were not circulated and the proposed initiative measure was not submitted to the people for a vote.

The medical associations in the states named assumed the lead in thwarting the selfish interests behind these proposals, interests that would subordinate the public welfare to their own private ends. In California and Colorado the state medical associations, aided by many lay and other professional groups and by public-spirited citizens, informed the people fully of the dangers implicit in the proposals. To bring these dangers to the attention of the voters necessitated great sacrifices of time and money, but the results show that such sacrifices were well worth while and indicate that an informed electorate will support scientific medical care under proper legal and ethical safeguards. —*American Medical Association News Sheet.*

* * *

U. S. Migratory Aid Sought

Allocation of more federal funds for medical aid to California's thousands of migratory workers was urged yesterday by Dr. W. M. Dickie, director of the State Department of Public Health.

Present facilities, he said, are limited to the low available funds and man-power of his department and the Federal Farm Security Administration. He continued:

"Medical needs of these migratory workers showed an increase during November and will mount through the winter months. Additional provisions must be made for them. At the same time, the general public must be protected from the danger of contracting infectious diseases from them."

A major difficulty, Doctor Dickie declared, is the fact that a vast majority of the migratory workers lack the residence requirements to make them eligible for aid from local health departments.—San Francisco *Chronicle,* December 22.

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Democrats Map Health Plan

Legislature to Get Administration Program

Examiner Bureau, Sacramento, December 19.—Lieutenant-Governor Ellis E. Patterson said the new Democratic administration will submit a quasi-State health insurance program to the 1939 Legislature.

After studying newspaper accounts of the plan proposed at a Los Angeles meeting of the California Medical Association, Patterson indicated the Association's plan does not fully meet ideas of the incoming administration.

The administration program, instead of allowing eligibles a salary maximum of only $2,500 annually, would admit persons with incomes up to $5,500 and include a provision for care of indigents and unemployables, he indicated.

He said the party is committed by its platform to a state plan, expressing the belief that California physicians attempting to operate a "closed corporation" plan eventually would ask the state to take it over.—San Francisco *Examiner,* December 20, 1938.

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Sprague Appointed to Health Board

Sacramento, December 24.—(AP).—Dr. Norman F. Sprague, Los Angeles, was appointed today by Governor Merriam to succeed Dr. George H. Kress as a member of the State Board of Health for a term ending January 15, 1941. Doctor Kress resigned on July 1, 1938.—Los Angeles *Times,* December 23, 1938.

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Spirit of Labor-Capital Coöperation Seen in Program at Forthcoming Session of Legislature

Indications that a broad spirit of coöperation between capital and labor will be evident in the program if the State Chamber of Commerce decides to support at the forthcoming session of the Legislature marked initial meetings of the organization in the Fairmont Hotel yesterday, as the thirteenth annual convention got under way with more than 1,000 delegates registered. . . .

Coincidentally, directors will have the following recommendations before them: . . .

Prepare statistics on unemployment compensation, old age insurance, health insurance, so California may move intelligently for or against any law governing them. . . .—San Francisco *Chronicle,* December 2, 1938.

* * *

Nonpartisan League Will Back State Health Insurance Measure

With the opening of legislative headquarters here, J. Vernon Burke, secretary of Labor's Nonpartisan League, announced today that the organization will sponsor a state health insurance measure at the coming session.

While Burke said financing plans have not been developed, it has been suggested that the money be raised by a payroll levy. Both California residents and migratory workers would be eligible for benefits. . . .—Sacramento *Bee,* December 15, 1938.

* * *

Medical Insurance Arrives

The campaign for medical insurance, which farmers have been waging in California, is now bearing fruit.

The California Medical Association has gotten a "divorce" from Dr. Morris Fishbein, secretary of the American Medical Association, who has been leading the fight against "socialized medicine," and the California group announces a health insurance plan which sounds practical, and humanitarian.

Details are not complete, but the California Medical Association proposes to set up a service by means of which citizens may pay a flat rate per month and go to the physician, surgeon or hospital of their choice for needed attention. This service is to be furnished by the members of the California Medical Association, who comprise about 90 per cent of the leading doctors of the state, and they will be reimbursed from the state insurance fund. The fund is to be non-profit, the monthly payment for the service to be based on the actual cost, as experience may reveal.

An effort to get the Dental Association to coöperate was not successful. Perhaps this may come later.

If the plan is carried out on the broad basis on which it is visioned, this will avoid state medicine and political control. It does not require any additional legislation, or extra equipment.

This is the sort of service the farm groups have asked for. They wanted to pay to be kept well, and be able to budget the necessary expense. This does not interfere, of course, with free medical service for indigents, nor does it put any compulsion on those fortunate citizens who do not have to worry about the cost of medical service, and may prefer to leave it to chance. But to a great many homes it will be welcome relief.

Thus the Medical Association is to be congratulated for meeting the request of agriculture.—*Pacific Rural Press* and Petaluma *Argus-Courier,* November 28, 1938.

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The California Farm Bureau Federation, with enlarged membership and new hope, met in its twentieth annual convention at Sacramento last week and adopted a broad work sheet for the future. . . .

The Farm Bureau has deposited in its new home at Berkeley a membership roll covering 23,129 farm families.

The convention rejoiced that the California Medical Association has agreed to furnish health insurance, and it renewed its demand that county hospitals be opened to paying patients.

Over 1,800 delegates from all over the state registered at the convention and visitors from many other farm groups participated in the discussions of the program ahead.

Farmers seek to do their part.—*Pacific Rural Press,* November 26, 1938.

* * *

Ballot Expenses Listed

Three Hundred Thousand Dollars Spent Vainly to Pass Initative No. 1 on Labor

Sacramento, December 12.—(UP).—Opponents to the Labor Initiative No. 1 on the November ballot spent about $100,000 and organizations supporting the defeated measure expended more than $300,000, Secretary of State Frank C. Jordan reported this week.

More than fifty organizations and individuals have filed financial reports with Jordan, as required by law. . . .

Chief expenditures against No. 2, the Humane Pound Act, were: B. C. Raulston, M. D., and George D. Maner, M. D., Los Angeles, $5,314; California Medical Association, $14,423; California Society for Promotion of Medical Research, $29,545. Favoring the act were the California Citizens' Committee, $3,189; California Committee, $12,077. The act was defeated. . . .—Santa Cruz *Sentinel,* December 13, 1938.

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Socialized Legal Aid League Forms in State

Sacramento, December 22—(INS).—Socialized legal aid for the poor and middle-class citizens of California was proposed in Sacramento today when the "Socialized Law League" filed articles of incorporation with Frank C. Jordan, Secretary of State.

The League, which proposes to create a "socialized law commission" of five members, plans to seek legislative approval of the plan, and, in the event of failure, place the matter before voters of the state in the form of an initiative measure.

The socialized law, Lieutenant-Governor Ellis Patterson said today, would be supported by the Democratic contingent in both houses if the bill is properly drawn.

He likened socialized law to socialized medicine, picturing a great need for both as arms of state government.

He said the people needed this protection so that the poor might stand on an equal basis with the rich before the bar of justice.—San Francisco *Call-Bulletin,* December 22, 1938.

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United States Recognizes State Problem

Washington, December 19—(AP).—Government experts reported today that along with a big increase in agricultural employment since 1910, California had acquired a "serious" migratory labor problem.

Summarizing results of a nation-wide survey, they informed Works Progress Administrator Harry L. Hopkins the state's farm labor force increased from 211,898 to 300,105 in the period from 1910 to 1935, and added this comment:

"The organization of agriculture in California is somewhat different from that in other areas, being characterized by a high degree of specialization, the cultivation of intensive crops which have high seasonal labor demands, the presence of many large farming units, and a high degree of mechanization.

"The proportion of the total labor force composed of hired workers is distinctly greater than the remainder of the country. Further, this proportion has increased somewhat throughout the period studied."

In 1910, the experts reported, 102,764 of the 211,898 persons employed in agriculture were "family workers," while the rest were hired. By 1935 there were 172,232 family and 127,873 hired workers.—San Francisco *Chronicle,* December 19, 1938.

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Aid on Migrant Health Sought

State to Request Added Federal Assistance to Meet Farm Worker Problem

In view of the impending session of Congress and health conferences in Washington, Dr. W. M. Dickie yesterday began a campaign for more public health and medical assistance for migratory workers from the Federal Government.

The State Health Director pointed out that increased assistance is vital not only to relieve the ills of migrants and their families, but also to protect the general health of Californians.

"California is now approaching the peak of the migratory labor problem," Doctor Dickie announced. "Applications for medical aid may be expected to mount during the winter months."—San Francisco *Examiner,* December, 22, 1938.

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Drop Noted in Number of Migrants

Only 1,302 in Need of Work Entered State Last Month, United States Reports

The Farm Security Administration today reported 1,302 out-of-state families "in need of manual employment" entered California during November, 1938, as compared with 2,132 families during November, 1937.

Jonathan Garst, regional director of Farm Security Administration, said the figures were based on a survey by the agricultural plant quarantine border stations.

A "family" consists of 4.65 individuals, according to Farm Security Administration calculations.

"The records only show workers entering California," Mr. Garst said, "and take no account whatever of those leaving the state. There is, of course, a very considerable flow of such families leaving California."

Since June 1, 1935, 60,759 families in need of manual employment have arrived in California from out of state by auto. The decrease in numbers crossing the border has been sharper since April, 1938, than at any time since the border count was started.

"The decrease can only be ascribed to the fact that there was not work available in California," Garst said.—San Francisco *News,* December 26, 1938.

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Health Group Files Appeal*

The Pacific Health Corporation, a San Francisco group health association, yesterday appealed to the United States Supreme Court from a State Supreme Court decision that it practiced without a licence.

By selecting physicians to administer to its members the health organization actually was practicing medicine in violation of the state's medical practice act, the State Court held.

In asking the high tribunal to void the decision, the corporation, according to Associated Press dispatches from Washington, D. C., did not question the validity of the California law in so far as it prohibited any unqualified or unlicensed physician from practicing medicine.

The appeal was the second development in two days in the fight over group health. Tuesday the Department of Justice obtained indictments against the American Medical Association, three affiliated societies and twenty-one physicians on a charge of violating the antitrust laws.—San Francisco *Chronicle,* December 22.

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San Francisco City Health Service; Doctors Paid in Full

The City Employees' Health Service System completed its October business yesterday by mailing the last check to doctors on its panel.

All bills were paid at the full rate of $1.00 per unit, according to Jesse C. Cameron, System secretary. Checks totaling $13,433 were sent to 342 of the approximately one thousand physicians coöperating with the health insurance plan.

The month's operations left a balance of $701 in the medical fund and $577 in the administration fund, though the System was under heavy expenses for equipment and installations.

A rush to enroll dependents before the November 15 deadline for acceptance of new members without medical examinations brought the total membership as of December 1 up to 14,853, of whom 9,615 were employees and 5,238 dependents. October membership fees, deducted by the controller, amounted to $26,217, those for November, $30,735.—San Francisco *Chronicle,* December 8, 1938.

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Doctors Paid $13,433 Under San Francisco Health Plan

Surplus of $1,278 Left After Payments for October

Checks totaling $13,433 were in the mails today—on their way to 342 physicians in the city—as payment for services rendered during October to city employees and dependents, under the city's health service plan.

After payment of the medicos, plus hospital and laboratory costs amounting to $4,323, a surplus was left of $1,278, to carry over.

Income Increases

Meanwhile, income of the health service increased during November to approximately $26,000, owing to a sizable increase in number of members.

Under new regulations in effect November 15 it became necessary for dependents of city employees, desiring to join the service, to undergo physical examinations. In the two weeks prior to examinations becoming mandatory, numerous wives, husbands, fathers and children signed up.

2,050 New Members

Total new members in the "health club," from September 21 to November 15, was 2,050. At the present time 9,675 city employees are in the group, and 5,238 dependents.—San Francisco *Call-Bulletin,* December 8, 1938.

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Newspapers Pledge Support to Eaton*

Pledges of coöperation and fair treatment in interpreting his acts in Congress were given Representative-elect Tom Eaton yesterday by newspaper editors and publishers of the Eighteenth Congressional District at a farewell luncheon at Lakewood Country Club. After the luncheon Eaton and his family departed by auto for Washington.

Twelve publishers representing sixteen of the twenty-two newspapers in the district engaged in a frank discussion of local problems and issues. All offered full support of the new Representative.

Efforts to prevent the seating of Eaton next January 3 were condemned by Carl Fletcher, former Mayor of Long Beach and editor of the *Labor News,* who termed the tactics of certain groups in attempting to make a political target of Eaton as unfair and poor sportsmanship. He desired to go on record publicly, he said, against such maneuvers and also opposed the move to contest the election as threatened by the outgoing Representative.

Fletcher's remarks were considered significant in view of his opening statement that his paper had supported Eaton's opponent during the recent campaign.

Joe D. Williams, publisher of the Bellflower *Herald-Enterprise* and also a supporter of Representative Scott in the campaign, said that he felt it his duty now to give his fullest coöperation to the successful candidate. — Long Beach *Press.*

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Congressman Scott Files Vote Contest

Washington, December 27—(AP).—Congressman Byron N. Scott (D.) of the Eighteenth California Congressional

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* For text of the California Supreme Court decision see CALIFORNIA AND WESTERN MEDICINE, October, 1938, page 306.

* Congressman-elect Eaton of the Long Beach-Los Angeles County district defeated Congressman Byron Scott. Congressman Scott was the sponsor of the bill in the last Congress to investigate the American Medical Association.

District, filed an election contest today against Mayor Thomas Eaton of Long Beach, his Republican opponent who defeated him by 326 votes.

The contest was filed with the contest election committee of the House of Representatives. Scott's representative here said notice of the contest was served in Decatur, Illinois, yesterday on Eaton by the Sheriff of Macon County.

Scott's twenty-five point complaint charges, among other things, violation of the Califorinia election laws and corrupt practices act.—San Francisco *Chronicle*, December 28, 1938.

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Postgraduate "State-wide" Medical School Planned

California's doctors will go back to school next year to keep pace with rapid developments of medical science.

The "school" will be taught by specialists and instructors from California's four medical colleges, who will travel to cities outside the metropolitan areas under a five-year plan of postgraduate study announced here today by the California Medical Association.

The purpose of the plan, explained by Dr. John C. Ruddock of Los Angeles, chairman of the Committee on Postgraduate Activities, is to enable physicians who can't continue their studies at the medical schools to learn about new developments, new techniques and new drugs.

"It enables the practitioner," Doctor Ruddock said, "to remain abreast of scientific progress and to apply in his daily practice the newer procedures with an understanding of their underlying principles and fundamentals."

Suggested educational centers were Stockton, Fresno, Riverside, San Bernardino, San Diego, Santa Barbara, San Jose, Santa Rosa, and Sacramento. The committee contemplated forming teams of clinicians to conduct series of conferences in more distant Northern California cities.

Dr. George H. Kress, Secretary of the Association, said the committee hopes to have the plan under way before spring.—Los Angeles *Herald and Express*, December 19.

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How Prepayment Hospitalization Works

Health . . . Lots of folks we know in Lodi are members of hospital associations. For a small monthly fee—a dollar and up—they are entitled to hospital care, medicines, operating room, dressings, x-rays and the like. You can even have a baby produced at the hospital and cared for, all for the monthly fee. But married couples can't decide to have a child and then cash in on the policy. Must be a member for several months before assuming blessed parenthood. A man our hospital scout knows was badly smashed up in a car accident, along with another fellow. Our scout's man had a policy, but the other victim was on his own. Both were cared for, and three weeks passed before they were discharged. The policyholder didn't pay a nickle for his care; his partner in pain wrote a check for $112 to cover his bills. Pays to have a policy, what?

Expensive . . . A national survey just released tells you about the high cost of illness. Every day in the year an average of four million folks are hit by illness. The cost of sickness and the premature deaths in this nation is ten billion dollars a year. A staggering sum, indeed.

Deaths . . . The survey shows that infant detaths can be reduced by one-half. Every year there are two million babes born here. And one million babes never survive. This is just plain murder when you know that the million little folks would live if they had good care. One million infants are in families either on relief or who have an annual income of less than $1,000. If these families were enabled to take out hospital policies, see what a difference it would make in the mortality rate.

Relief . . . There is now a movement to fix up a deal for the poor folks so they can have advantage of hospitals and doctors. It will require a staggering sum to care for the million babes that die each year. Far better to cut out some of this WPA spending and put the money where it will at least give poor folks an opportunity for good health and insure life to their babies. The poor we will always have with us. The most we can do is to keep them healthy. They can find their own happiness.—Lodi *Times*, December 7, 1938.

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County Extends Quarantine in Rabies Drive*

More Poundmen Hired; State Threatens to Kill Stray Dogs

Faced with the most serious rabies menace in the history of Santa Clara County, the Board of Supervisors yesterday widened the quarantine to include all unincorporated areas and increased the field force of poundmen to six and trucks to three.

If rabies is not stamped out here within sixty days by these measures, Santa Clara County is in danger of having the state take over the situation with "shot-gun squads who will shoot stray dogs and cats on sight," according to Supervisor Joseph M. McKinnon.

"We hope the public will coöperate with county officers during the next sixty days in helping eradicate rabies, because we don't want drastic action taken," McKinnon said yesterday.

The supervisors voted yesterday to widen the quarantine and increase the field staff, after County Health Officer C. M. Burchfiel, meeting with the Board in executive session, stressed the seriousness of the rabies situation.

The quarantine formerly covered the northern part of the county, but stopped short at Edenvale. Rabies is rapidly increasing in southerly areas, according to Doctor Burchfiel, who reported six new cases in the Gilroy-Morgan Hill district since December 1.

The six men and three trucks were voted by the supervisors for a period of sixty days. Formerly the county health office had at its disposal one full-time and one half-time field man, and one and a half trucks.

Doctor Burchfiel's recommendations to the supervisors followed the visit of Edward Ross, chief of the State Bureau of Sanitation in the State Department of Public Health, here last week.

Ross said he believes the rabies situation in this county constitutes a serious menace to the public health," Burchfiel said. "Unless the public will coöperate with the health authorities and police in combating the scourge, sooner or later human lives will pay for the public's apathy," Ross declared.

If the state takes over the extermination of rabid animals, the expense of the drive will be charged to the county, Burchfiel added.

The county quarantine does not include incorporated areas such as San Jose and Palo Alto, which have their own quarantines.

Appearing before the supervisors at an earlier meeting yesterday, Mrs. Frank Thomas of Palo Alto, state humane officer, proposed that the Board assess a license fee of $1.00 for male dogs and $2.00 for females in unincorporated areas.

"The adoption of some kind of restrictive ordinance, one imposing a tax on all dogs, would give enforcement officers weapons to work with, and the poorer sections of all communities, which are usually hotbeds of propagation, would be cleaned up," Mrs. Thomas said in a letter to the Board.

The Board filed the letter for future consideration.—San Jose *Mercury-Herald*, December 13, 1938.

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Merriam Attends Napa Medical Party

Napa (Napa County), December 10.—Governor Frank F. Merriam is scheduled to be one of a score of honored guests who will be present at the Napa Valley Country Club tonight when the Napa County Medical Association holds its annual Christmas Jinx.

More than one hundred doctors and their guests, coming from all parts of the north bay district, will attend, according to Dr. George I. Dawson, chairman.

Among the guests attending will be:

Harry Lutgens, State Director of Institutions; Dr. F. O. Butler, Director of the Sonoma State Home; Judge Percy S. King of Napa; Dr. Junius B. Harris and Dr. Roy Green, both of Sacramento; Assemblyman Ernest C. Crowley; Senator H. W. Slater of Santa Rosa; Assemblyman H. B. Scudder of Sebastopol; Senator Thomas Keating of San Rafael; Dr. S. S. Bogle of Santa Rosa; Dr. L. L. Stanley of San Quentin Prison; Dr. Henry S. Rogers, Councillor of the Northbay District of the California Medical Association, and many others from Northern California.

Each year the Medical Association, headed by Dr. Walter Rapaport, of the Napa State Hospital, stages the annual jinx.—Sacramento *Bee*, December 10, 1938.

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Medical Meeting in Mendocino County

Ukiah, December 9.—A dinner meeting of the Mendocino-Lake Medical Association will be held at the Mendocino State Hospital, Saturday evening.

Dr. George H. Kress, Secretary of the State Medical Association, will speak on medical insurance, and Dr. William Shepherd of the Metropolitan Life Insurance Company will show films on pneumonia.—Santa Rosa *Republican*, December 9, 1938.

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Hospital Executive Meet

J. O. Thorpe, general manager of the Intercoast Hospitalization Insurance Association, returned tonight from a conference with executives of the three California nonprofit hospital service plans, which was held at the California Club in Los Angeles. The other two plans are the Insurance Association of Approved Hospitals in the San Francisco bay area and the Associated Hospital Service of Southern California.—Sacramento *Bee,* December 5, 1938.

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* See also Bedside Medicine Symposium on Rabies, in this issue, on page 30.

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Physical Examination Law In Oregon Slows Up Cupid Trade*

Portland, Oregon, December 11. — Poor Dan Cupid is mighty near bankrupt in the Oregon branch of his business. It wasn't bad management, either.

Dan was doing all right until the high cost of marriage began before the license could be issued.

Not that romance is dead. Heaven forbid! It's just that a trip to bordering state is no more expensive than the medical examinations now required in Oregon.

One prospective bridegroom struck the attitude of most Oregon couples when the Multnomah County license clerk told him what permission to wed would cost. "The h— you say," he muttered, and backed hastily through the door.

A new law, which went into effect a week ago, stagnated the wedding business. It requires physical examinations and Wassermann tests for men and women alike, for which physicians may collect $10 from the couple.

That isn't all. Licenses may be refused if parents or grandparents were afflicted with "epilepsy, feeble-mindedness, insanity, drug addiction or chronic alcoholism." Possession of a venereal disease is an absolute bar.

After the sworn statement of the applicants and physician are recorded, the couple still has to wait three days for a license—a holdover from an earlier law—and then pay $3.00 for it. That doesn't include the minister's fee.

Margaret Klees, Multnomah County license clerk, found some consolation in the situation, despite the fact that she could issue no licenses for several days because the prescribed blanks were not available.

"Most couples seem prepared to pay the price," Mrs. Klees commented. "If they can't, they shouldn't be getting married anyway."

One question bothered her.

"Where are you going to draw the line in refusing licenses?" she demanded. "Lots of people have been treated for insanity, but have completely recovered. I know lots of men who could be called chronic alcoholics, but they handle their businesses successfully and are highly intelligent, desirable citizens. Where do their children stand?"

Mrs. Klees thinks the law will work "when people get educated to it."

Meantime, Vancouver and Walla Walla, Washington, just over the Oregon border, Western Idaho, Nevada, and California points are doing a rushing business—even though California requires a three-day wait for a marriage license. —San Jose *Mercury-Herald,* December 12, 1938.

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First Flea Lab Near Opening

A two-story building dedicated to study of the lowly flea was near completion today at the University of California Medical Center, the first flea laboratory in the world.

Dr. Karl F. Meyer, superintendent, said the new laboratory will be used for beginning of highly important pioneering studies into sources of bubonic plague among animals and other problems.

City dwelling two-bit flop house fleas are not the problem, Doctor Meyer said. It's their second cousins which infest squirrels, chipmunks and other wild life that are the disease carriers.—San Francisco *Call-Bulletin,* December 13, 1938.

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Merriam Attends "Christmas Jinx" of Medical Group

The "Christmas Jinx," annual affair sponsored by the Napa County Medical Association tonight at the Napa Valley Country Club, will be attended by Governor Frank F. Merriam as one of the score of distinguished guests to join in the holiday fete.

More than one hundred doctors and their guests are expected to attend the stag affair, which is held under supervision of Dr. Walter Rapaport of Napa State Hospital, President of the County Association. Dr. George I. Dawson, chairman of the evening, announced that there will be no speakers, since the program is purely social.

Among the many distinguished guests who will be in attendance are Harry Lutgens, State Director of Institutions; Judge Percy S. King, Dr. F. O. Butler, Director of Sonoma State Home; Assemblyman Ernest C. Crowley, Senator H. W. Slater of Santa Rosa, Assemblyman H. B. Scudder of Sebastopol, Senator Thomas Keating of San Rafael, Dr. S. S. Bogle, Santa Rosa; Dr. L. L. Stanley, San Quentin Prison; Dr. Henry S. Rogers, Councilor of the Northbay District of the California Medical Association; Dr. Junius B. Harris and Dr. Roy Green, both of Sacramento.

Feature of the evening's entertainment will be the appearance of the Medical-Dental band of eighteen pieces, who will come from Oakland for the evening. Professional entertainment will also be on hand for the program. Doctor Dawson said today that all plans were complete, and that the program was one of the biggest ever planned.—Napa *Journal,* December 10, 1938.

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Lutgens, Rosanoff Will Discuss Mental Hospitals

Sacramento, December 14—(AP).—Harry Lutgens, State Director of Institutions, had today announced a conference for next Saturday with Aaron J. Rosanoff, Los Angeles, who will succeed him under the Olson administration.

Construction at the state mental hospitals to relieve congestion will be one of the principal subjects under discussion. A $4,000,000 appropriation has been discussed for inclusion in the next biennial budget with $4,500,000 remaining unexpended in the current budget.—San Francisco *Call-Bulletin,* December 14, 1938.

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Hospitalization Group Insurance Offered Chamber

Group hospital insurance was the topic at the Chamber of Commerce meeting, held Monday at the Horseshoe Grill.

Dr. F. M. Stump led the discussion by stating that a life insurance company had offered a proposition to the Chamber of Commerce, whereby the members, as a group, could take out hospital insurance for as low as 67 cents per month for males, $1.00 for females, $1.00 for wives, and 40 cents each for children.

The plan would give free hospitalization to all members for a period of seventy days for any one period of disability.

If the plan is accepted by the Chamber of Commerce it will have the distinction of being the first to have ever been offered such a plan. A speaker will come next week to further explain the plan.—Crescent City *American,* December 9, 1938.

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Health Film Shown Today

A preview of "A New Day," a film sponsored by the City Department of Public Health, was to be shown at 2 p. m. today at the Twentieth Century-Fox Film Corporation studio, 245 Hyde Street.

The moving picture, which features Gilbert Emery and a full Hollywood cast, represents the fight being waged by the Department of Public Health to reduce the number of deaths by pneumonia. The film extends over a ten-minute period. It had an initial run of a week at the Radio City Music Hall in New York City.

Plans are now under way to present it before the public here, according to Dr. J. C. Geiger, Director of Public Health.—San Francisco *Call-Bulletin,* December 13, 1938.

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Olson Appoints Doctor Rosanoff

Dr. Aaron J. Rosanoff, fifty-nine, operator of a private San Gabriel sanitarium and member of the Los Angeles County Lunacy Commission since 1923, today was appointed Director of State Institutions by Governor-elect Culbert L. Olson. He will take office January 2.

He is a charter member and former president of the Southern California Academy of Criminology.—San Francisco *Call-Bulletin,* December 5, 1938.

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Socialized Medicine Will Be Film Theme*

Hollywood, December 26.—Once again Hollywood is snagging a movie idea out of the newspaper headlines. Sam Goldwyn is going to town rushing his writers through a script of "I Am a Doctor," based on the current fight between the American Medical Association and the Government, over socialized medicine. In fact, Sam is sending scripters to Washington, D. C., to cover the trial of Dr. Morris Fishbein, editor of the *Journal of the American Medical Association,* and other doctors opposed to the idea of "a dollar down and a dollar a month for medical attention."

Sam is lining up an interesting cast, with Joel McCrea set for the rôle of the young doctor who believes in socialized medicine, and Walter Brennan, who almost stole "Kentucky," in another top spot. But particularly interesting is the news that Richard Bennett, father of Joan and Connie, is being sought for the rôle of the famous surgeon who is opposed to medicine on the installment plan.—San Francisco *Examiner,* December 27, 1938.

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* By Paul F. Ewing.

Of interest because similar laws will be submitted to the 1939 California Legislature.

* By Louella O. Parsons, Motion Picture Editor, International News Service.

Graduate Conferences: Doctors Focus on Pneumonia

San Francisco, December 19—(AP). — Pneumonia was singled out today from among all the ills of mankind for the concentrated attention of California's doctors.

The selection was made by the California Medical Association Committee on Postgraduate Activities in preparing plans for a traveling medical college.

The Peripatetic School, to be started within the next three months, will be staffed by experts, who will hold classes in a dozen cities throughout California to keep practicing physicians in touch with the latest developments of medical science.

"The average total yearly deaths from pneumonia in California reaches over four thousand," said Dr. John C. Ruddock, committee chairman.—Los Angeles *Times*, December 20, 1938.

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State Bar Considers Health Age Aid Plan for California Lawyers

Feasibility of an insurance plan for California lawyers which would cover funeral and burial expenses, medical service, hospitalization, retirement annuity, sick benefits and loan privileges was being considered today by the Board of Governors of the State Bar to whom it was proposed by William C. Ring, Los Angeles attorney.

Asking that the Board appoint a committee to study the matter and report to the 1939 convention of the organization, Ring said that "it is pitiful to find ninety-four lawyers who are so destitute as to be unable to pay their state bar dues." This was the number recently suspended from practice for such nonpayment.

He said he believed that full coverage insurance could be provided by a unit organized by the State Bar at comparatively inexpensive rates.

Ineligible for United States Aid

"Aside from the purely humanitarian aspect, I feel that some such plan is demanded by national economics and a reasonable security against professional delinquency," Ring stated in his communication to the Board. "Self-preservation is the first law, and the system of jurisprudence or code of ethics, which undertakes to enforce moral decency without taking the former into account, is estopped to assert its own violations."

He pointed out that the lawyer group is one of those not protected in the federal security plan, and said that under existing conditions "the complete coverage type of insurance every lawyer should have is too expensive for the average individual."

Will Provide Security

"In the past," he said, "the average lawyer has had little to look forward to in his profession in the way of old age security. Existing conditions negative the possibility of security by ordinary saving. Incomes do not permit it. But an insurance plan, contemplating monthly dues, commencing while the lawyer is young, will provide him a living anuity in forty years.

"It will also provide him with a small loan facility to defray current expenses. The records will never tell the entire story of professional delinquencies, precipitated by economic pressure, which might have been averted had there been available a source for procuring necessaries."—Los Angeles *Evening Herald and Express*, December 23, 1938.

LETTERS

Subject: The Motion Picture, "A Man to Remember."

Los Angeles County Medical Association
Los Angeles, California,
December 6, 1938.

To the Editor:—On Monday, December 5, a representative group of members of the Council of the Los Angeles County Medical Association and officers attended a preview of the motion picture, "A Man to Remember," produced by the R. K. O. Studio. The picture will be released this week.

The Council at its meeting last night, upon motion duly made and seconded, recommended this picture to the membership and instructed the editor to prepare an editorial relative to it for the Bulletin.

It is the opinion of the men who witnessed this picture that it is one of the best portrayals of the old family doctor ever to come out of a motion picture studio.

Attached is a copy of the editorial to appear in the current issue of the Bulletin.

It is suggested that other county societies be advised of the merits of this production, and asked to watch for its release in their respective communities.

Cordially yours,
George D. Maner, M.D.,
Secretary.

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"A Man to Remember"

Motion Picture Eulogizing the Family Physician Is Recommended by the Council—Members Are Urged to See it.

"A man to Remember" is a motion picture to see; if seen it will be remembered, not only by the members of the profession it eulogizes, but by the millions of theatergoers, who, during the coming months, will be profoundly affected by it.

Motion pictures come and go. In recent years a number of them have been brought to the special attention of medical men. Some of these productions have been based upon medical themes; have been fairly accurate historical presentations depicting the advance of scientific research and the resultant benefits to humanity. They unquestionably have played an important part in educating the public to the value of scientific medicine.

Never, however, had the Council of the Los Angeles County Medical Association, gone on record as formally recommending any motion picture to the members until its meeting on Monday evening, December 5, when it adopted a motion recommending the current release, "A Man to Remember," produced by R. K. O. Studios, and now being shown at Pantages, Hollywood, and R. K. O. Hill Street theaters.

Every doctor is urged to view this picture; to consider its value, to recommend it to his friends and his patients as he undoubtedly will so see fit.

In the past there have appeared pictures in which the man of medicine plays a part; pictures that have exaggerated isolated instances to cast aspersion upon the entire profession in attempts to create drama at any cost.

"A Man to Remember," the story of a family physician in a small city—is in reality the story of a countless number of family physicians who devote their lives to the healing of the sick, who are living examples of what the Oath of Hippocrates means; men who work for humanity only, regardless of themselves. A picture such as this, with its honesty of purpose and its wholesome drama, is indeed welcome.

Members of the Council attended a special preview of this picture and went away greatly impressed by it, not only because it is a story of one of their own profession, but because it is a story that is great in itself and which should have tremendous dramatic appeal for all laymen as well as physicians.

Especially to be commended is the artistry of Edward Ellis in the rôle of John Abbott, M.D., "A Man to Remember."

Subject: Thanks from the American Red Cross.

The American Red Cross
National Headquarters
Washington, D. C.
December 5, 1938.

To the Editor:—Please allow me to express to you in behalf of our national officers our very sincere appreciation for the generous contribution of space which you gave to the American Red Cross in the California and Western Medicine. It is through the splendid coöperation which you and others give to us each November that we are enabled to extend a universal invitation to all Americans everywhere to participate in Red Cross work through individual memberships.

Cordially yours,
Douglas Griesemer,
Director of Public Relations.

Subject: Third Congress of the Pan-Pacific Surgical Association.

To the Surgeons of the Countries of the Pacific!

My dear Colleagues:

The Third Congress of the Pan-Pacific Surgical Association to be held in Honolulu, September 15 to 28, 1939, is an occasion of more than average significance for every surgeon practicing in the nations bordering on the Pacific.

The Association was organized in 1929 by surgeons from China, Australia, New Zealand, Japan, Canada and the United States, meeting together in Honolulu. At this meeting those in attendance became keenly aware of the great value of bringing together at regular intervals men from the ends of the vast Pacific area, and it was voted to hold similar assemblies in Honolulu at three- or five-year intervals.

The aims of the association as embodied in the Constitution adopted at that time are simply:

1. To bring to Honolulu surgeons from countries bordering on the Pacific Ocean, so as to permit the exchange of surgical ideas and methods.
2. To further the principles of hospital standardization.
3. To develop an acquaintanceship among the surgeons so that they may be instrumental in developing a spirit of good fellowship among the races bordering on the Pacific.

There is no great burden of organization. Membership is by attendance, and the dues are the registration fee of $25 for the Congress attended.

A postgraduate session, to follow the Congress for ten days, is planned. Details as to courses and instructors are not yet available but will be made known to the chairman of your country as soon as definitely arranged.

The medical men of Hawaii are arranging many pleasurable activities for the afternoons and evenings that the Congress is not in session. The week-ends will be available for tours to the other islands of the Hawaiian group. No place in the world offers so much in the way of diversion, relaxation, and rare scenic charm as Hawaii, so picturesquely called the "Paradise of the Pacific."

"Pahi," 64 Symonds Street,
Auckland, New Zealand.

Cordially yours,
J. Hardie Neil, *President.*

Subject: Lure of Medical History article on bubonic plague in California by George H. Evans.*

(copy)

Treasury Department
Public Health Service
National Institute of Health
Washington, D. C.
December 21, 1938

George H. Kress, M.D.
Editor, California and Western Medicine,
San Francisco, Cal.

Dear Doctor Kress:

Referring to your letter of December 2, I have just received the copy of the journal referred to therein, and have read Doctor Evans' article with much interest. I had delayed writing until receiving this copy, thinking that some further comment might be called for in view of my own brief paragraphs on plague in San Francisco in Supplement 141, but none seems necessary. I shall look up the other chapters of Doctor Evans' contribution.

I have requested the publications section at the Bureau to forward to you a copy of Supplement 141 and trust that you will receive it promptly. Only a small edition was printed, since it was intended more for a record than for general distribution, and I have no remaining copies for personal disposition.

Sincerely yours,
A. M. Stimson,
Medical Director, United States Public Health Service.

Subject: Letter from possible beneficiary member of the California Medical Association Medical Service.

(copy)

San Jose, California,
December 6, 1938.

California Medical Association.

Gentlemen:

In the November 26, 1938, issue of the *Pacific Rural Press*, appears an article saying "Medical Insurance Arrives," and goes on to say, "Citizens may pay a flat rate per month and go to a physician of their choice."

I'm writing to ask if this service is now in operation, and how does one join, and where? Both my husband and I need medical care, but, on part-time pay, cannot afford the very costly services of a good doctor, and we will not run up a large bill that we cannot pay.

I will be glad to pay a regular fee per month, if real medical service is available. If this is not now in effect, how soon do you expect it to be?

In my own opinion (and experience) medical insurance will be a great boon to the small-salaried group, and please hasten it along.

Thanking you in advance for your reply, I am

Sincerely,
(Signed): ————————

SPECIAL ARTICLES

FEDERAL GRAND JURY OF DISTRICT OF COLUMBIA AND THE AMERICAN MEDICAL ASSOCIATION*

AMERICAN MEDICAL ASSOCIATION AND TWENTY-ONE DOCTORS INDICTED AS TRUST

Monopoly in Medicine Charged—Federal Action Follows Fight on Coöperative Health Plan

Washington, Dec. 20 (INS).—The powerful American Medical Association, three professional societies, and twenty-one nationally known leaders in medicine and surgery were indicted by a federal grand jury today on charges of violating the antitrust laws.

Specifically, this blue-ribbon aggregation was accused of the alleged restraint of a group health movement undertaken by hundreds of low-income workers.

The indictments were returned after two months' investigation by the grand jury with the assistance of the Department of Justice and its investigators, and culminated the first phase of a history-making official action against organized medicine.

DR. FISHBEIN INDICTED

Chief among those indicted were:

Dr. Morris Fishbein, known as the "voice of American medicine" in his capacity as editor of the *Journal of the American Medical Association.*

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* See following issues: November, page 383; December, page 458; this issue, page 24.

If present plans do not miscarry, Medical Director Stimson's article will appear in the February issue.

* Because of the importance of the issues involved, generous space is given for a presentation of press articles concerning the District of Columbia controversy, regarding which articles have appeared in previous issues.

Olin West, secretary and general manager of the Association.

William C. Woodward, director of the American Medical Association Bureau of Legal Medicine and Legislation.

William D. Cutter, secretary of the Council on Medical Education and Hospitals of the American Medical Association.

Rosco G. Leland, director of the Bureau of Medical Economics of the organization.

SOCIETIES ACCUSED

The three professional societies named with the Medical Association were the Medical Society of the District of Columbia, the Harris County Medical Society of Houston, Texas, and the Washington Society of Surgery.

It was the first time in history that the Federal Government had resorted to the antitrust laws in proceedings against the medical profession, and if the defendants are found guilty they are subject to a maximum fine of $5,000 or a year's imprisonment, or both.

The grand jury charged that the defendants conspired to thwart the operations of Group Health Association Inc. of Washington, D. C., a nonprofit coöperative association, formed in Washington about a year ago and claiming about 2,500 members.

OBSTRUCTION CHARGED

The organization seeks to provide medical care and hospitalization to its members on a risk-sharing prepayment basis.

The defendants, according to the indictments, combined and conspired to hinder and obstruct the group health organization's efforts in obtaining qualified doctors for its medical staff.

All doctors who were willing to assist the Group Health Association were threatened with disciplinary action, it was alleged. In one case the defendants expelled one of their colleagues from the medical society of the District of Columbia for participating in the group health plan, the jury charged further.

The Harris County (Texas) Medical Society was drawn into the case on charges it took "disciplinary action" against a doctor who had joined the health group. The doctor belonged to the Texas society and the discipline was undertaken at the alleged instance of the Washington society.

The Texas society later dropped all charges against the doctor.

BARRED AT HOSPITALS

The jury also found that the defendants sought to prevent the Group Health Association from obtaining access to hospitals in Washington and to prevent medical treatment for operations in these hospitals on the part of the organization's doctors.

The grand jury noted that because of the unprecedented advance in medical knowledge and technique that has taken place during the last few decades costly diagnostic and therapeutic equipment and facilities are now available.

Many persons within the low-income groups throughout the country cannot afford, as individuals, to obtain complete and adequate medical care, the jury held. It added that group medicine, "if not obstructed by coercive restraints," may contribute to the solution of providing complete and adequate medical care to persons with small incomes.

ONE HUNDRED AND TEN THOUSAND AMERICAN MEDICAL ASSOCIATION MEMBERS

Of the 145,000 doctors engaged in practice in the United States, approximately 110,000 are members of the American Medical Association. The jury emphasized that, because of the American Medical Association's great influence in the field of medicine, any plan that meets with the organization's disfavor can be easily thwarted.

The indictment set forth that the *Journal of the American Medical Association,* which has a weekly circulation of 95,000, has been edited in a manner to express opposition to group practice on a risk-sharing prepayment basis.

In addition the jury found that the American Medical Association's Bureau of Medical Economics has taken a leading part in opposing, discouraging, and suppressing group medical practice.

OTHERS INDICTED

Included in the indictments were Dr. Arthur Carlisle Christie, Coursen Baxter Conklin, James Bayard Gregg Custis, Thomas Allen Groover, Robert Arthur Howe, Leon Alphonse Martel, Thomas Ernest Mattingly, Francis Xavier McGovern, Thomas Edwin Neill, Edward Hiram Reede, all of Washington.

Also Drs. William Mercer Sprigg, William Joseph Stanton, John Ogle Warfield, Jr., Prentiss Willson, Wallace Mason Yater and Joseph Rogers Young, also of Washington.

* * *

FISHBEIN HURLS DEFENSE CHALLENGE

Chicago, Dec. 20 (AP).—Dr. Morris Fishbein, spokesman for the American Medical Association, when informed of the federal indictments returned in Washington today for violation of the Sherman Antitrust Act, said:

"The House of Delegates has authorized the Board of Directors of the American Medical Association to defend the case to the limit."—San Francisco *Call-Bulletin,* December 20.

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TWENTY-ONE HIGH MEDICAL FIGURES INDICTED IN UNITED STATES TRUST PROBE

Fishbein, Indignant, Maps Bitter Legal Fight

Washington, Dec. 20—(INS).—A Federal Grand Jury today took history-making action against the medical profession by indicting the powerful American Medical Association, three professional societies, and twenty-one outstanding physicians and surgeons on charges of violating the antitrust laws.

The indictments accused them of consipring to restrain a group health program for workers in the low-income bracket.

LEGAL BATTLE

The action culminates two months of investigation by the grand jury with the aid of crack Justice Department attorneys and raised the curtain for a bitter, last-ditch fight between the Federal Government and the medical profession. Of the 145,000 doctors in this country, 110,000 are members of the American Medical Association.

Announcement of the jury's action provoked a determined declaration in Chicago by Dr. Morris Fishbein, official spokesman of the American Medical Association, that his organization will fight the indictments with all its resources. Doctor Fishbein, who is editor of the journal of the Association and is one of those indicted, declared:

"My only comment is this: The House of Delegates of the American Medical Association has authorized the Board of Trustees to use, if necessary, the last resources of the Association in defending this case. Our attorneys have advised us to say only that much."

Besides Doctor Fishbein, others indicted included:

Olin West, secretary and general manager of the Association; William Creighton Woodward, director of the American Medical Association Bureau of Legal Medicine and Legislation; William Dick Cutter, secretary of the Council on Medical Education and Hospitals of the American Medical Association; Rosco Genung Leland, director of the Bureau of Medical Economics of the American Medical Association.

MANY INDICTED

The three professional societies indicted with the American Medical Association are the Medical Society of the District of Columbia, the Harris County Medical Society of Houston, Texas, and the Washington Society of Surgery.

Other individuals indicted are: Drs. Arthur Carlisle Christie, William Mercer Sprigg, William Joseph Stanton, John Ogle Warfield, Jr., Prentiss Willson, Wallace Mason Yater and Joseph Rogers Young, Coursen Baxter Conklin, James Bayard Gregg Custis, Thomas Ernest Mattingly, Francis Xavier McGovern, Thomas Edwin Neill, Edward Hiram Reede, all of Washington, D. C.

Announcement of the indictments rocked the medical world. Never before has the Federal Government proceeded against the medical profession by invoking the antitrust laws. The defendants face a maximum fine of $5,000 or a year's imprisonment or both, if found guilty.

SPECIFIC CHARGES

Specifically, the Grand Jury charged:

1. The defendants conspired to restrain the functioning of the Group Health Association, Inc., of Washington, D. C., a nonprofit coöperative association of Government employees, claiming 2,500 members.

2. They conspired to frustrate efforts of the Washington group to obtain qualified doctors for its staff, threatening disciplinary action and in one case actually expelling from the Washington Medical Society a physician who participated in the group health program.

SOUGHT TO HALT AID

3. They sought to prevent the Group Health Association from using Washington hospitals and to prevent medical treatment or operations in the hospitals undertaken by doctors affiliated with the movement.

4. The American Medical Association's journal, which has a weekly circulation of 95,000, opposed group medical practice on a risk-sharing prepayment basis.

5. The American Medical Association's Bureau of Medical Economics played an active rôle in opposing, discouraging and suppressing such group medical programs.

6. The staffs of hospitals in Washington are rigidly regulated by the Medical Society of the District of Columbia, an American Medical Association affiliate.

7. Washington hospitals did not give access of regular facilities to the group health organization because they feared loss of prestige if the American Medical Association resorted to reprisals.

The Grand Jury took cognizance of the great strides taken by the medical world in the field of research and technique and that costly diagnostic and therapeutic equipment and facilities are available. But, it added, many in low-income brackets cannot pay for this, as individuals. The Jury insisted that group medicine, "if not obstructed by coercive restraints," could very well help solve the problem of providing adequate care for those of small incomes.—San Francisco *Examiner,* December 21.

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UNITED STATES INDICTS MEDICAL ASSOCIATION AND TWENTY-ONE DOCTORS AS TRUST LAW VIOLATORS

Action Result of Battle Over Health Service

Washington, Dec. 20 (AP).—A legal fight fraught with major import for the future history of medical care in the United States began today when a Federal Grand Jury indicted the American Medical Association, three affiliated societies, and twenty-one leading physicians on a charge of violating the Sherman Antitrust Act.

The Medical Association announced immediately that it would throw all its energies into the battle against the charge. Dr. Morris Fishbein, leader in the Association, said at Chicago that its House of Delegates had authorized its Board of Directors to "defend the case to the limit."

The indictment grows out of a fight by organized medicine against Group Health Association, Inc., a coöperative set-up in Washington to provide medical care for Government workers who pay periodical, risk-sharing fees in advance.

RESTRAINT CHARGED

The charge is that the defendants conspired to restrain trade by preventing physicians hired by the coöperative from practicing in Washington hospitals or consulting with other doctors. It is also alleged that one doctor was ousted from the District of Columbia Medical Society because of his work with the coöperative, and that proceedings were started against another for the same reason.

Thurman Arnold, new assistant Attorney General who contends the antitrust laws have not been rigorously enforced in the past, instituted the action against the Medical Association and the others named defendants today.

The indictments, copies of which were released by the Department of Justice when the Grand Jury returned its report, names, besides the Medical Association, the District of Columbia Medical Society, the Washington Academy of Surgery, and the Harris County (Texas) Medical Society.

DOCTORS INDICTED

Also named defendants were Doctor Fishbein, who is editor of the American Medical Association journal; Dr. Olin West, secretary and general manager of the Association; Dr. William C. Woodward, director of the Association's Bureau of Legal Medicine and Legislation; Dr. William D. Cutter, secretary of the Council on Medical Education and Hospitals of the Association, and Dr. Rosco Genung Leland, director of its Bureau of Medical Economics.

Sixteen Washington physicians were also named in the indictment.

Indications are that the Association may carry the case to the United States Supreme Court, if necessary, with the contention that its operations cannot be restricted by the Sherman Act since medicine is not a trade but a profession. Attorneys for the Association have emphasized that point repeatedly.

BACKGROUND OF CASE

Behind the case is a strenuous controversy over methods of providing medical care. At the National Health Conference here last July, President Roosevelt's Committee on Health and Welfare declared that about one-third of the population—those in families with incomes of less than $1,500 per year—receive practically no medical care and are unable to meet the expense of sudden illness.

It recommended the establishment of prepaid medical insurance programs for such groups. These would be patterned after the Group Health Association in Washington.

The American Medical Association was critical of such organizations, contending that supervision of medical care would be placed in the hands of officers of the organizations instead of being directed by physicians, and that patients would not receive proper care as a result.

It is now proposing, through its member societies, the establishment of prepayment medical care associations which will be organized and supervised by the local medical groups.—San Francisco *Chronicle,* December 22.

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AMERICAN MEDICAL ASSOCIATION INDICTED BY GRAND JURY

Federal Body at Washington, D. C., Returns True Bill Against Group Charging Trust Law Violations

Washington, Dec. 20 (UP).—A Federal Grand Jury today returned indictments against the American Medical Association, three other medical societies, and twenty-one individuals, charging violations of the antitrust laws. The indictments were based on charges that the American Medical Association and affiliated medical organizations used unfair tactics in opposing the coöperative Group Health Association, members of which include many Government employees.

Outcome of the case is expected to determine the fate of coöperative medicine in the United States—and ultimately may have far-reaching effects on every individual practicing medicine or receiving medical care.

FISHBEIN INDICTED

The indicted individuals included Dr. Morris Fishbein of Chicago, editor of the American Medical Association's journal, and prominent spokesman for the medical profession.

In addition to the American Medical Association, indictments were returned against the Medical Society of the District of Columbia, an affiliate of the American Medical Association; the Harris County Medical Society of Texas, and the Washington Academy of Surgery.

Assistant Attorney General Thurman Arnold announced the Government's intention to seek indictments against the American Medical Association and the Medical Society last August, five months after he left his professorship of law at Yale.

THREE PRACTICES ASSAILED

He named three specific practices which, he said, violate federal antitrust laws:

Threatened expulsion from the Medical Society and virtual professional ostracism for doctors who joined the Group Health Association staff;

Threatened expulsion for doctors who consulted professionally with Group Health Association staff members, and

Exerting influence on Washington hospitals to refuse Group Health Association doctors use of their facilities.

These tactics, Mr. Arnold said, operate to deprive individual members of Group Health Association of the services of the doctor they select—when they enter a hospital their Group Health Association physician is not allowed to care for them.

Seth Richardson, attorney for the American Medical Association, said he had expected the indictments.

He added that "the defendants and ourselves believe the Government is proceeding on a glaringly illegal basis."—San Francisco *News*, December 20.

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INDICTED MEDICAL CHIEFS MAP FIGHT

Association and Twenty-One Doctors Deny Guilt

Chicago, Dec. 20—(INS).—Legal experts of the American Medical Association, which was indicted with twenty-one nationally known medical leaders and three other societies, were preparing tonight for a finish fight against charges of antitrust law violation.

All officials of the Association will plead not guilty, their Chicago attorney, Edward M. Burke, announced.

Dr. Morris Fishbein, editor of the journal of the Association, spokesman for the medical organization, and one of the twenty-one indicted, declared:

FIGHT PROMISED

"The House of Delegates of the American Medical Association has authorized the Board of Trustees to use, if necessary, the last legal recourse and the last resources of the Association in defending the case."

Doctor Fishbein also quoted from a statement by the House of Delegates after it had received a report from a special committee to which recently was referred the threat of the Department of Justice to seek indictments against the American Medical Association and its leading members.

The statement, issued last September, said:

"Your Reference Committee highly commends the Board of Trustees for its willingness to submit to investigation by any authorized agency on the nature of its organization work, conduct, and activity.

INDICTMENT FORESEEN

"Firm in a belief in the probity of our officers, and confident of their adherence to established federal law, your Reference Committee recommends that, in the event of an indictment, this House of Delegates gives full support to the Board of Trustees in defending such litigation to the utmost, with every means in its power, exhausting, if necessary, the last resource of distinguished legal talent, to establish the right of organized medicine to use its disciplines to oppose types of contract practice damaging to the health of the public."

NOT EXCITED

Dr. Olin West, secretary and general manager of the Association and another of the prominent medical men named in the indictment, took the news of the Federal Grand Jury's action more casually, saying:

"This is not altogether unexpected, of course. We are not going to get excited about it.

"For the life of me, I can't see how the anti-trust laws apply to the medical profession. It seems to resolve itself into a question of whether medicine is a profession or a trade.

"If it is a profession—which seems reasonable—I do not believe it can come under the antitrust laws.

"We have had no direct communication with the Department of Justice on this matter. We did receive several subpoenas for records which we gladly turned over to them. All of our files are open to the Department whenever they wish to use them."—San Francisco *Examiner*, December 21.

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MEDIC ASSAILS INDICTMENTS

Portland, Oregon, Dec. 22 (AP).—Dr. R. G. Leland, director of the Bureau of Medical Economics of the American Medical Association, called the sixteen federal indictments returned on Tuesday against members of the District of Columbia Medical Society and five American Medical Association officials the "most diabolical persecutions of the medical profession we have ever witnessed."

He spoke before the Multnomah County Medical Society.—San Francisco *Call-Bulletin*, December 22.

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INDICTING THE AMERICAN MEDICAL ASSOCIATION

The indictment of the American Medical Association, three local medical societies, and twenty-one individual physicians under the Sherman Act is probably the silliest piece of business the opinionated and bureaucratic New Deal has yet indulged in. Unless the courts completely lose sight of the patent facts, they will be compelled to rule that physicians and medical associations are engaged neither in trade nor commerce and hence do not come under the Antitrust Act; and the dismissal of the indictment will be haled by Dr. Morris Fishbein as a triumphant vindication.

It may be granted that both Doctor Fishbein and some others of the ruling spirits of the American Medical Association have gone to unreasonable lengths in opposing group health organizations. But this situation is in process of working itself out, as the recently announced plan of the California Medical Association indicates; the problem could undoubtedly be solved by concessions on both sides, which would safeguard both physicians and the public.

To subject this body of physicians, which as a whole acts with the best of intentions according to its lights, to criminal prosecution is to misuse the powers of governmental authority and probably to defeat its own object. The opposition of the American Medical Association to particular forms of group medical supervision may be and probably is mistaken in some particulars, but it is sincere, and as far as possible from indicating criminal intent.—Editorial, Los Angeles *Times*, December 21.

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CASE OF DOCTORS: SOCIALIZED MEDICINE

But—Says Boake Carter

The mass production mania has now engulfed the medical profession.

The Government has succeeded in obtaining indictments against the American Medical Association and twenty-one of the nation's leading physicians and surgeons as conspirators to violate the antitrust laws and prevent "trade."

The "trade" is group medical practice performed on a coöperative basis. The scene of the battle is the District of Columbia.

The group medicine disciples charge the American Medical Association with bringing pressure to bear on hospitals and the 120,000 out of the 140,000 doctors in the United States who are members to prevent the operation of group medicine.

The medical profession retorts that the Sherman Antitrust Law cites restraint of "trade"; that the practice of medicine is not a "trade" but a "learned profession"; that anything which prevents the right of a patient to free choice of his own doctor is dangerous to the public health.

* * *

There are many points to be remembered before taking up cudgels for either side. First, the Government is pushing the case and the Administration has a mass-production public health scheme it desires to foist upon the public. The indictments, therefore, serve as excellent government propaganda, even should the Government lose the case in a court of law.

Further, if organized medicine is not permitted to lay down some code of ethics and rules, by which doctors must be guided in their conduct, and by which they may be disciplined for infraction, why does the same administration encourage the formation of labor unions, which establish rules by which workmen are disciplined when they break the rules?

There are various kinds of organizations which give group medical care in the United States. Their number totals well over two thousand. Upon hundreds the American Medical Association has stamped its approval because they did not violate the fundamental right of a patient to pick his own doctor. But there are others which do not permit such free choice and which, furthermore, require a third party to hire and sublet the physicians' services. In obtaining the indictments the Government has made no effort to make this vital differentiation clear to the public.

* * *

It is conceded that the American Medical Association is not perfect. This writer long ago contended that its control was too conservative for these modern days; warned that rigidity of control would some day flare back in its face. It must also be acknowledged that the American Medical Association has eased its codes considerably in the past five years. But in any case it is the guardian body which sustains the high standards of healing used in the United States, and it is pitiable to see the power of the United States Government being used to undermine the confidence of laymen in the integrity and decency of their doctors.

To be sure there are crooked doctors. But are there not also crooked lawyers? If the Government desires to bedevil the American Medical Association as an organization restraining "trade," then let the Government also bedevil the American Bar Association for similar reasons.

This, of course, it would never do. There are too many lawyers working for the Government!—San Francisco *Examiner*, December 27, 1938.

MEDICINE'S GIFT TO MANKIND

From its very beginnings the science of medicine has contributed vastly to the happiness of human beings, an editorial in the December issue of *Hygeia* says. Even man of prehistoric days trephined the skull to relieve pains coming from pressure within. Yet these simple efforts were only the beginning of a process which was eventually to free mankind from the greatest tyrant that he has ever known, the tyrant of fear; and of all fears which disturb mankind the greatest is the fear of pain, suffering, disease and death. In an earlier period in the history of man, hundreds of thousands of human beings were destroyed by disease and by great plagues which used to sweep across the world. Today the people who live in civilized communities no longer fear smallpox, typhoid, yellow fever, bubonic and pneumonic plague, trypanosomiasis, cholera, leprosy or even syphilis. One by one the causes of the infectious diseases have been discovered, the means of transmission have become known, and these diseases have been eliminated or at least brought under control.

Before the time of Pasteur, surgery was limited to just a few simple operative procedures, including amputation of limbs. There were but few physicians competent to invade the interior of the human body. Then came our understanding of the germ causation of disease, and the demonstration by the famous Lister of the possibility of eliminating infection. Before our knowledge of the germ causation of disease and before the introduction of antiseptics and of aseptic methods, surgery was viewed with horror by every person confronted with the necessity for an operation. Forty-five per cent of amputations resulted fatally. Hospitals smelled to high heaven with the pus, the decay and the inflammations of infected wounds. Today there is no portion of the human body which the surgeon does not invade; lives are greatly prolonged; the operating room is a clean, white refuge for those who require its service.

Life expectancy of man at birth in the United States has moved up from an earlier thirty-five years to almost sixty-one years, and it is conceivable, with suitable application of what medicine now knows in relation to hygiene and in relation to the control of the degenerative diseases, that life expectancy may be advanced an additional five years. The physician has coöperated with health departments, with authorities in schools and with newspapers, radio networks, and other means of public information to spread widely the knowledge of the nature of disease and of the methods of prevention. Thus the physician is perhaps the only worker in all the world who spends most of his time destroying the conditions by which he has gained his livelihood. Vast numbers of people now share the knowledge of medicine, which is no longer held a mystery. The frontiers of medicine are constantly changing. Medicine is a living, vital science, constantly moving to attack new problems that arise. It has given vastly of itself to mankind in the past, and it stands ready to give more, if it can, in the future. It makes to mankind no promise of immortality or even of eternal youth; but it does offer to those who are ready to receive its gifts, increasing years of usefulness.—*American Medical Association News.*

HOW NEW FEDERAL ANTITRUST "CODES" ARE DRAFTED

How Are the New "Codes" for Industry Drafted? What Is the Source of the Regulations? The Answer Is Given Here

The new technique of the Department of Justice for enforcement of the antitrust laws continues to raise questions important to business.

If a group of industrial or union or professional leaders is indicted on charges of violating those laws, for example, exactly what can it expect as the next step?

Thurman Arnold, Assistant Attorney General, who heads the Antitrust Division, explains that in certain instances the Government will ask dismissal of the criminal indictments if the defendants agree to reforms of benefit to the public.

But there has been a missing link in the public explanations made of the procedure to date. That link itself is a question:

How can the defendants in a particular case learn just what reforms the Government would accept as justifying dismissal of the indictments?

SOURCES OF REGULATIONS IN THE NEW "CODES"

First impressions, from the statements of Mr. Arnold and other officials, were that the Department of Justice would make no suggestions for inclusion in "consent decrees," as the new codes of fair practice are known. Inquiry develops that this is not exactly the case, however.

What happens is this:

Counsel or friends of the defendants approach the Department of Justice with suggestions that they would like to negotiate for a code. They are told that one can be submitted by them, that the Government lawyers will look it over, and reply.

In the course of informal conferences, according to Department of Justice men who have participated in the procedure, ideas inevitably are exchanged. If the proposed code is considered unsatisfactory, then the Government may or may not suggest the inclusion of other reforms.

This is said to be what occurred during the weeks of discussion which preceded the agreement between the Department of Justice and the Ford and Chrysler automobile companies that led to a dropping of antitrust charges against those companies. It is still not clear whether the Government or the companies' participants suggested inclusion of promises to change certain financing and advertising practices.

CHICAGO MILK INDUSTRY MAY ACCEPT DECREE

Now to look ahead.

Certain milk producers, distributors and public officials in Chicago have been indicted. The case may never go to trial, because a consent decree or code may be accepted as the best way out.

The Department of Justice, it is learned, has asked the Department of Agriculture for suggestions about what conditions of benefit to the public might well be written into such a code. If counsel for the defendants begin negotiating for a code, then the Government lawyers and economists will have the chance to suggest reforms which go beyond the law but which the Department of Agriculture would like to effect.—*United States News,* December 5.

VOLUNTARY AND COMPULSORY HEALTH INSURANCE

Medical indemnity insurance for voluntary prepayment of doctors' bills, as an alternative to state-controlled compulsory health insurance, was advocated recently by Dr. Peter Irving, Secretary of the New York State Medical Society, talking before the Rotary Club of New York.

Doctor Irving explained that many types of socialized medicine are successful and receive the support of the medical profession, such as the control of communicable diseases and of tuberculosis and pneumonia, as well as the maintenance of state and municipal hospitals.

"But should the State," said Doctor Irving, "try to extend its medical activities further through compulsory health insurance so as to accompany the doctor across the threshold of the sick room and place the hand of government upon the patient's pulse, then the doctor must clearly register his remonstrance.

"Compulsory health insurance is supported by contributions from the employees' pay envelope, the employers' payroll, with an added contribution from the state. The doctor looks with alarm at the possibility that the administration of the service will be controlled by a political bureaucracy. Yet he is interested in any measures that can be taken which would help more people to get good medical care. Hospital insurance of the voluntary kind with government entirely out of the situation has proved itself successful to cover part of the risk of illness. This does not include the doctor's bill. The latest suggestion to fill this gap is voluntary nonprofit insurance. Such plans are now in a formative state. The law at present does not permit such associations to organize, but the New York State Medical Society will seek to obtain amendments to the laws so that they can operate."

Doctor Irving explained that this type of insurance would permit participation by all groups of the public, whereas compulsory health insurance applies only to the worker, and does not cover his family in European countries where it has been tried. The vast group of farmers and professional people are also not within its scope, he said.

"Red tape mechanism under compulsory health insurance," said Doctor Irving, "takes up the time of the doctor which he needs for study or rest; there intrudes into the practice of his profession an office force supervising his methods of diagnosis and treatment and dictating the remedies he uses. His waiting room is overcrowded; he has less time than is necessary to properly carry out the work of diagnosis and treatment.

"With tax funds an ingredient in the system, and a further sickness tax levied on employer and employee, political control is inevitable. This seems a real danger because the Government, in making contributions to the necessary funds, would surely feel it a duty to supervise administration. While it is not my place, perhaps, as a practitioner to go into the economic side of this type of socialization in medicine, there are some things that I think it is fair for me to point out for consideration of business men. One of these is the fact that this is pure socialized medicine though employer and employee make contributions. These contributions are made under the compulsion of law whether the employer or employee wishes to participate or not, and become therefore taxes. Largely these taxes come from business and would have to be figured in financing.

"Another thing to think of is the possibility that business, if medicine should be completely socialized—and compulsory health insurance would certainly be a step that way—would have issued an invitation for socialization of other pursuits including business. How much that is a danger in the United States is for the people of this country to decide.

"The doctor judges all these matters of socialization from a single standpoint of whether or not they will work out in practice to provide patients with the best medical care it is within his power to give."—*Medical News,* Medical Society of the State of New York.

HIGH INFANT MORTALITY*

Laid to Economic Irregularities; Declared Preventable

As one of the government's departments represented on the President's Interdepartmental Committee to Coördinate Health and Welfare Activities, and as the agency responsible for fostering, promoting and developing American wage earners' welfare, the Department of Labor is keenly interested in the health needs of mothers and children.

The generation in which most of us came to maturity was shocked by gross inequalities found between slum areas and favored sections of our great industrial cities. This early concern with city poverty is still justified.

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* By Katherine F. Lenroot, Chief of the Children's Bureau, Department of Labor, Washington, D. C.

Only within the last five years has overwhelming evidence been accumulated regarding inequalities in standards of living among the great geographical regions into which our country is divided, and among major occupational groups, such as farmers and nonfarmers.

It is the poorest areas with lowest levels of living that have the largest ratio of child to adult population and that constitute the reservoir for population replacement for the rest of the country.

INFANT MORTALITY HIGH IN RURAL AREAS

Since 1929 infant mortality rates have been higher in rural areas than in cities. The National Resources Committee reports rural people die in relatively greater numbers from diseases of childhood—measles, scarlet fever, whooping cough, diphtheria—and from certain diseases of adolescence and young adult life such as tuberculosis. These are diseases toward control of which medical science has made greatest progress.

Reports from state health departments received within recent months by our Children's Bureau translate into terms of motherhood and childhood these general statements and averages.

In a northwestern state it was reported that two-thirds of the total population did not have funds for medical and dental care, that few physicians were left in rural areas and that some counties had no physicians.

The outstanding need was said to be medical care for mothers and babies.

In the Middle Atlantic States the county health officers estimate that one-third of the states' public health nursing effort is fruitless because of lack of adequate shelter, coal, food, blankets and clothing.

In a southern state it is reported two counties are without physicians because of the people's economic condition, widely scattered population and distance of other communities from any medical service. One-third of all babies born in this state are delivered by midwives.

In a mountain state it is reported that in one county there is no physician and that all the babies born during the coming year will be delivered by midwives. Many people in that state live more than 100 miles from a hospital.

TWO WAYS INEQUALITIES CAN BE REDUCED

There are two ways in which inequalities among regions and occupational groups can be reduced and standards of living improved:

1. By increasing economic opportunity through introduction of new industries or agricultural undertakings; expansion of more efficient organization of old industries or agricultural activities or migration to areas of more favorable economic opportunity.

2. By introduction or expansion of tax-supported services to supplement the economic resources of families; to provide families with a minimum of security against death, accident, illness or other major catastrophes; and to supply those elements in the standard of living which depend on community effort with tax support rather than on individual purchase.

TOTAL YEARLY LOSS OF 160,000 LIVES

It is essential that both these lines of endeavor be carried on simultaneously. It is also essential that there be clear understanding of the place of continuing tax-supported services for health, education, social security and social welfare, as a normal contribution to a higher standard of living.

A total yearly loss of approximately 160,000 maternal and infant lives, at least half of which is preventable, places upon us a grave obligation to find a solution.—San Francisco *Examiner*, December 11, 1938.

PROCRASTINATION, THE THIEF OF LIFE IN CANCER*

The subject of my talk is "Proscrastination, the Thief of Life in Cancer." It is evident that this title is a simile of the old proverb, "Procrastination is the Thief of Time." The latter is a saying which, liberally interpreted, means, "Do not put off until tomorrow what you can do today."

Let us first consider how this proverb may apply to cancer. The disease—cancer—is always fatal unless treated. On the other hand, if it is recognized in the early stages and is properly treated, it is curable. Therefore, if we recognize this condition in the beginning, when it is curable, and we neglect or delay going to our doctor at once, we procrastinate and in this respect procrastination is the thief of life when dealing with cancer.

During the past ten years great effort has been put forth to educate the public in regard to cancer, and it may be said that much has been accomplished, for most people have some knowledge about this disease. However, the desired results have not been obtained. Many people who recognize suspicious symptoms neglect to take advantage of this knowledge and have delayed in consulting their doctor, fearing they might be told they have cancer. This fear is now one of the stumbling-blocks of our success in the cure of cancer. We have several reliable methods for the cure of early cancer, but none for advanced cancer. Cancer is a progressive disease and always fatal if not treated. The early symptoms are not specific, and similar signs may be caused by other conditions. Therefore, an individual who may fear cancer because of certain signs will be greatly relieved to find upon examination by his doctor that there is no cancer; but if cancer is present, the one chance for recovery lies in its early recognition and treatment.

Cancer never begins as cancer but almost always as some inflammatory or abnormal condition which exists for a considerable period of time before the malignant change takes place. These inflammatory conditions which may change into cancer are sometimes called precancerous conditions and in nearly all cases give symptoms which may be observed by the individual, and if we consult our physician at once these inflammatory conditions are corrected and we prevent cancer. If the change has already taken place, it is probable that we have discovered the cancer at its inception. I wish to emphasize the fact that cancer is a localized disease in the beginning, and at this time it is curable, for we can remove the cancer cells by a surgical operation or we can destroy them by x-ray or radium.

Cancer may occur in almost every organ or tissue in the human body. Those that occur in the mouth, on the lip and the skin are easily recognized when they begin to grow. They usually start as a sore or ulcer which does not readily heal. Most of the deeper cancers are not easily recognized, but they nearly always give some symptoms. Cancer of the stomach is associated with digestive symptoms. Such symptoms occurring especially after the age of thirty demand an immediate examination by your doctor. X-ray is one of the methods used to discover early cancer of the stomach. Cancer of the bladder and of the urinary tract is often characterized by the presence of blood in the urine. Cancer of the large intestine is associated with blood or mucus in the stools.

Moles on the skin are very common and nearly everyone has them. There are two types of moles: one is the flat mole which rarely, if ever, becomes cancerous, and the other is the elevated mole. If an elevated mole occurs in a place where it is liable to become irritated it should be removed. Do not wait until it becomes deeper in color or bleeds easily. When this happens it has already become malignant and the chances of cure are greatly diminished.

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* By Burton T. Simpson, M. D., Director of the State Institute for the Study of Malignant Disease, Buffalo, N. Y.

White patches on the tongue or the lip from excessive use of tobacco frequently become malignant. A single lump in the breast of a woman, especially after the age of twenty-five, is a serious condition which demands immediate medical attention.

In all hospitals where cancer is treated it is the general experience that many patients have delayed in consulting their doctor. These patients become hopeless before a chance for curative treatment is obtained. One of the disappointing circumstances to physicians who treat cancer is the fact that many patients could easily have been cured if they had not delayed in seeking medical advice.

Statistics show that the cures obtained in cancer are in direct proportion to the interval between the time the patient first observed symptoms and the time when he consulted a doctor. The shorter this period was the greater the number of cures obtained, and the longer the interval the greater the number of deaths. Many people fear cancer because they believe it is incurable. This is an erroneous belief and is founded upon the fact that many people neglect the disease when they first discover it and only come for consultation when the cancer is advanced. There are thousands of people living who have been completely cured and remain free from the disease. It is needless to say that the majority of these consulted their doctors at the first appearance of symptoms.

Today we have excellent facilities for the diagnosis and treatment of cancer. Tumor clinics have been established not only in the large but in the smaller communities, and if we are to control this disease it is necessary for everyone to avail himself or herself of these facilities immediately upon the appearance of abnormal symptoms of any nature. I think you will agree with me, after this brief survey of the subject of cancer, that the necessity for seeking medical advice at once for any of the conditions mentioned above is imperative and that to neglect to do so substantiates the assertion that "Procrastination is the thief of life in cancer."

MENTAL HOSPITALS

Current incidence rates indicate that one of every twenty persons born in 1938 will be committed to a mental hospital some time during his life span.

Because of the increasing proportion of the population in the older age groups, an increase in the number of admissions to mental hospitals is to be expected in the future, since rates of mental disease are highest in the older age brackets.

Since there is no sharp line of demarcation between normality and abnormality, it is practically impossible to determine whether the relative number of persons with mental disease is increasing.

Fundamentally, even though there is a definite physical basis for many mental disorders, mental disease—or insanity, as it is popularly called—is a cultural concept, and varies from one group to another. In some situations the mentally deranged have become soothsayers, medicine men, prophets, or leaders; in other situations the same persons would be incarcerated.

These conclusions have been developed from a comprehensive study of recent data by Dr. Harold F. Dorn, statistician, United States Public Health Service. They are discussed by him in a paper, "The Incidence and Future Expectancy of Mental Disease," in the current issue of *Public Health Reports.*

To a certain extent, the increase in the number of first admissions to mental hospitals merely reflects an increase in hospital facilities, Doctor Dorn pointed out. In order to eliminate this factor in so far as it was possible, the data used in this study were the number of first admissions to mental hospitals in Massachusetts, New York, and Illinois, where facilities have been fairly adequate for several years. In general, these data do not support the contention that the incidence of mental disorders had been rapidly increasing.

This does not mean, however, that the public burden of caring for persons with mental disease has not been increasing. The average number of patients in state hospitals increased 40 per cent (from 248,852 to 347,620) between 1926 and 1935. But, rather, it means that most of the increase may be attributed to increase in the expectation of life, an increasing proportion of old people in the population, increasing urbanization, and other environmental factors. As the standards of care and treatment are raised the total cost will increase, although there is no increase in the incidence of the disease. (It is estimated that the current annual cost of hospitalized patients alone is between $150,000,000 and $200,000,000, and that these patients occupy 47 per cent of the total number of hospital beds.)

It is gradually becoming accepted, according to Doctor Dorn, that mental abberation is simply a form of illness which may often be cured or alleviated by suitable care and treatment. This attitude is clearly reflected by the fact that the "insane asylums" of fifty years ago have become "mental hospitals" today. Commitment to a hospital is no longer universally regarded with the same horror as formerly.

"This change in the public attitude toward hospitalization, which has been concomitant with a changing cultural conception of mental disease, has undoubtedly increased the frequency with which cases of mild mental disorders are hospitalized," Doctor Dorn declared.

"The increasing proportion of the population living in cities also tends to increase the use of hospital facilities. Many persons who would be regarded as merely 'queer' in a rural community undoubtedly experience difficulty in adjusting themselves to an urban environment. Moreover, due to inadequate housing, low income, and the uncertainty of continuous employment, home care of nonviolent cases of mental disorders, especially those associated with senility, is more difficult in the city than on the farm.

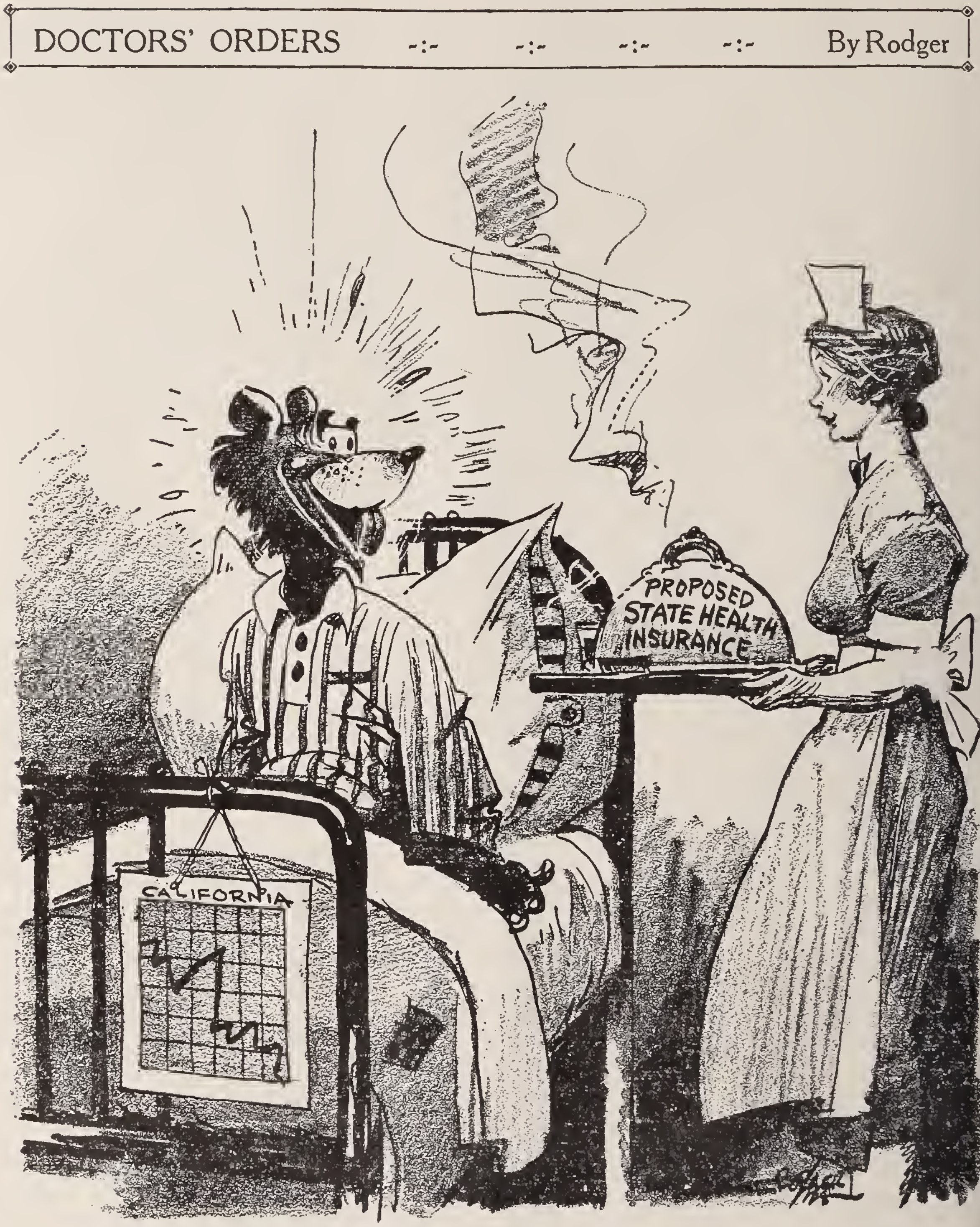
"The two principal exogenous factors which are thought to affect the prevalence of mental disease, alcoholism and syphilis are also more common in urban communities. For these reasons some increase in the proportion of the population thought to be mentally ill is to be expected even if there has been no real increase in the incidence of mental disorders."

However, it is impossible to determine whether or not this is true because there is no practical method of determining the incidence of mental disease either at the present time or in the past. Regardless of the amount of mental illness in the population, it must be measured by the number of mental cases recognized and committed to an institution.

"This method of measurement is not so unsatisfactory as might at first appear," said Doctor Dorn, "since cases of mental disease become a public burden only after they are recognized. Therefore, instead of speaking of the number of persons with some form of mental disease, a number which is unknown, it becomes necessary to restrict this discussion to the number of persons who are committed to a mental disease hospital. This does not, of course, include all persons with a mental disorder but merely those who have been recognized as needing institutional care and for whom hospital facilities are available."

Even if mental abberation apparently is not increasing appreciably, its importance should not be minimized, the statistician warned.

"The loss in future productive power as well as the cost of caring for this number of patients," he concluded, "emphasizes the importance of developing a thorough mental hygiene program. This is all the more important since the total burden of caring for the mentally ill is almost certain


DOCTORS' ORDERS -:- -:- -:- -:- By Rodger
PROPOSED STATE HEALTH INSURANCE
CALIFORNIA

I

Cartoon expressing appreciation by the California Bear on hearing news concerning the proposed Health Insurance of the California Medical Association.

From the San Francisco *News*, November 15, 1938. Cartoon appeared after the announcement on November 14, by the California Medical Association, concerning its tentative plans for a voluntary medical service system.

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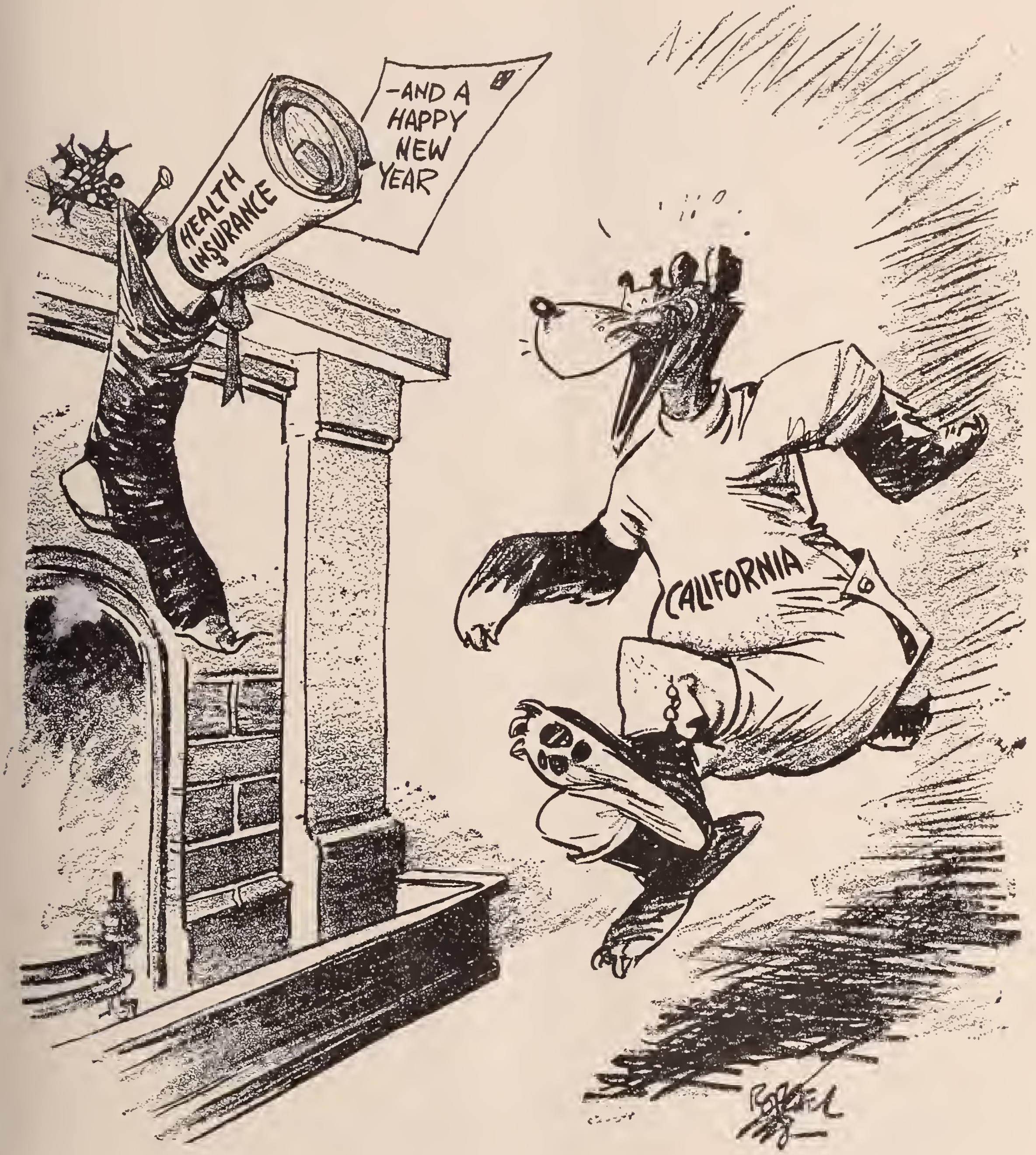
to increase even though there is no increase in the incidence of mental disease at each age. Changes now taking place in the national population presage an increase in the number of mentally ill in the total population because a larger portion of the population will be in the age groups when mental disease is most frequent. Assuming that the commitment rates for mental disease for the total United States are no greater in 1960 than they were in New York State during the three-year period, 1929-1931, it is estimated that about 135,000 persons annually will be committed to a mental hospital for the first time. This is nearly twice the present number of first commitments."

Only a few hundred years ago, the violently insane were thought to be possessed by demons and frequently were

A MERRY CHRISTMAS FROM OUR DOCTORS! -:- By Rodger



II

A follow-up cartoon from the San Francisco *News*, December 20, 1938. This cartoon appeared subsequent to the press reports of the Special Session of the House of Delegates of the California Medical Association, held in Los Angeles, December 17–18, 1938. For editorial, press and other items concerning the special session, see pages 35–48. Reprint by courtesy of the San Francisco *News*.

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illed or forced to leave the community. With some modi-ication, mainly the substitution of incarceration as a nethod of treatment, this idea of "insanity," as it was alled, prevailed later—indeed still prevails—in some laces. With increased knowledge of the functioning of the uman body, however, the concept of mental ill health has radually expanded until today it includes many conditions formerly considered normal. The recognition that mental ill health is more prevalent than hospital admissions reveal has led to the establishment of child guidance clinics, the employment of psychiatric social workers, the addition of psychiatrists to the staff of hospitals, prisons, and similar institutions, to devoting special attention to problem children in school, and to various adult education programs.

TWENTY-FIVE YEARS AGO†

EXCERPTS FROM OUR STATE MEDICAL JOURNAL

Vol. XII, No. 1, January, 1914

From Some Editorial Notes:

New Year—New Opportunities.—With its three hundred and sixty-five clean, unmarked pages, a new year has come to us to use or abuse; to write things upon them that will endure and be of benefit to the people, to the profession of which we are humble units, to the communities in which we severally live and work and have our influence; or to be left blank, soiled, scrawled upon or smudged. There is enough to do, God knows, in the way of helping ourselves and of helping the people whose needs and ills and sufferings we tend; and we must not forget that in helping ourselves to a better living, to a fuller life, we are helping the people. A physician poor in purse is handicapped to the extent that he cannot provide himself with the proper things of knowledge or material equipment with which to give the best that is in him to his patients. This we should not fail to recognize or to make our patients understand, as we have opportunity from time to time. There is nothing in the world more dangerous than a cheap lawyer except a cheap doctor. Let the new year see you follow more accurate and careful business methods in dealing with the business side of your work; no one respects the man he can defraud or cheapen, and your patients will respect you more for it. Do not let your accounts run for a year or two and then try to collect what you can; send out your bills promptly, and after a year of moderate effort to collect see that the debtor is forced to pay, if he is in a position to do so. . . . Above all, do not forget to do your own best work for the benefit of your own county medical society; it will help you and will help every member of the profession and will stimulate a greater respect for the entire profession in your community. Nothing hurts us all so much as rows among medical men themselves. A fight between two physicians not only hurts them both, no matter which one is in the right, but it hurts the whole medical profession by belittling its members in the eyes of the community. In every county where you find a good, active, well-knit county medical society, there you will find the medical profession looked up to and respected. There is plenty to be written on these clean pages of this year's new book; will you write something worth while?

* * *

Union Health Departments.—All over the country cities are engaged in becoming acquainted with themselves by means of efficiency surveys. These surveys have grown out of the perfectly natural desire of the taxpayer to know how his money is being spent, and whether he is getting value received. Wherever these surveys have been instituted, the health department is primarily the one which shows marked weakness in comparison to the other departments of administration. The reason of this is evident. As long as city councils and county boards of supervisors have the impression that the chief functions of a health department are limited to the placarding and fumigation of habitations after certain diseases, and the investigation and removal of the causes of bad smells, so long will the appropriations for health work continue to be inadequate. . . .

* * *

Public Health and Interference.—It seems a curious fatality to announce in a special health number of the JOURNAL the fact that the Secretary of the State Board of Health has resigned his office because of the intolerable interference with his work by some petty-minded laymen who really have nothing to say about it but who have usurped the right to say how every dollar of the money spent by the Board of Health shall be expended. Were it not a matter of the greatest importance to the people of the state, it would be farcical in the extreme. Doctor Snow has for several years served the state as Secretary of the State Board of Health and has served it intelligently and faith-

(Continued in Front Advertising Section, Page 15)

BOARD OF MEDICAL EXAMINERS OF THE STATE OF CALIFORNIA†

By CHARLES B. PINKHAM, M.D.
Secretary-Treasurer

News Items

"Dr. Morton R. Gibbons, Sr., noted surgeon in his own right and fifth in a family of medical men, will be in charge of the hospital to be operated at Treasure Island next year. . . . The hospital probably will be manned by three or four doctors and an equal number of nurses. . . ." (San Francisco *Chronicle,* November 4, 1938.)

"Dr. Aaron J. Rosanoff, fifty-nine, operator of a private San Gabriel sanitarium and member of the Los Angeles County Lunacy Commission since 1923, today was appointed director of state institutions by Governor-elect Culbert L. Olson. He will take office January 2. He is a charter member and former president of the Southern California Academy of Criminology." (San Francisco *Call-Bulletin,* December 5, 1938.)

"Because the only testimony against him was that of accomplices, Dr. Edward H. Anthony, physician, yesterday was granted a new trial on charges of participating in a fake-accident insurance swindle. The District Court of Appeal reversed the conviction by a jury in Superior Judge Charles Fricke's court, with the declaration that: 'After eliminating the testimony of accomplices, the record is devoid of any evidence, even slight, to connect Doctor Anthony with the commission of the crimes charged. The only evidence, excluding that of accomplices, is that Doctor Anthony treated the alleged injured persons, thereafter participating in discussions for the settlement of their claims and receiving in payment of his bill for professional service a portion of the money paid on these claims. These fees were not excessive.' The case was one in which three persons confessed they faked injuries to collect insurance. Doctor Anthony testified he believed their injuries legitimate and had no part in any criminal activities. . . ." (Los Angeles *Examiner,* November 19, 1938.)

"R. T. Church, forty-eight, foot ailment specialist, yesterday pleaded guilty to practicing medicine without a license in Police Judge E. E. Breitenbucher's court and was fined $100. Judge Breitenbucher also suspended a 180-day jail term, after Church admitted violations of the California Medical Act. He was arrested by Detective Sergeant Frank Ingalls and Detective Walter McLachlan." (Stockton *Independent,* November 11, 1938.)

"Denying his plea for probation, Superior Judge Lincoln S. Church today sentenced Dr. Boyajian B. Arman, fifty, to a term of one year in the county jail for unlawful possession of a narcotic." (Oakland *Post-Enquirer,* November 16, 1938.)

"Dr. John E. Baker, former Hollywood police surgeon, convicted as one of a fake accident ring conspiring to defraud insurance companies, will be paroled from San Quentin next April 2." (Los Angeles *Examiner,* November 18, 1938.) (Previous entries, July, September, 1937; April, 1928; September, December, 1937; January, April, 1938.)

" 'This court feels that this woman, who is not opposed to surgery, let her son die a horrible death because she refused to consent to an operation on the boy even after being warned his life depended on it.' The above statement was directed yesterday by Superior Judge A. A. Schott against Mrs. Lillian Volstad, whose son, Francis Warren Volstad, nine, died in General Hospital of a ruptured appendix. In commenting on the pitiful tragedy the jurist explained the mother refused to accompany her dying son to the hospital, adding—'And so we have the sorry spectacle

(Continued in Front Advertising Section, Page 23)

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† This column strives to mirror the work and aims of colleagues who bore the brunt of Association activities some twenty-five years ago. It is hoped that such presentation will be of interest to both old and new members.

† The office addresses of the California State Board of Medical Examiners are printed in the roster on advertising page 6.

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Public Health grew out of attempts to protect people against plagues and epidemics. Most of the ancient enemies are baffled—the defense warfare has been successful. Now public health is aggressive; it no longer waits for attack, but armed with the weapons of modern medicine, it strikes first. It anticipates attack by building health into the growing bodies of children and by planting health ideas in their plastic minds and it utilizes the weapons furnished by that quiet army of research workers that labors on untiringly, adding always more knowledge and power.

●

RECENT ADVANCES IN THE SCIENCE OF NUTRITION

V. Factors Affecting the Vitamin C Contents of Foods

● Recent development of the chemical method for estimation of ascorbic acid (1) has permitted more thorough study of factors determining the vitamin C contents of foods. Circumspectly used, the 2, 6 dichlorphenol-indophenol or "indicator" titration method for vitamin C determination has proven an invaluable tool in this phase of research.

It is now apparent that the vitamin C content of food at the time of consumption is conditioned, first, by the initial ascorbic acid content of the food at the time of harvesting, and second, by the treatment to which the food is subjected between the time of harvesting and the time of consumption.

The initial vitamin C level in raw foods has been found to depend on factors such as variety, maturity and growing conditions (2). Under usual conditions of food crop production, such factors are only partially subject to human control. However, the factors influencing vitamin C in foods from harvesting until consumption are capable of closer regulation by man.

For example, it is known that long storage at improper temperatures adversely affects the initial ascorbic acid contents of foods. Even at refrigeration temperatures raw foods may lose substantial amounts of vitamin C during storage. Rough handling—which causes rupture of vegetable tissue—is also conducive to vitamin C loss especially when followed by improper storage. Certain metals will catalyze vitamin C destruction and even commonly used home-cooking methods are attended by losses of this essential dietary factor (2).

Briefly, preservation of vitamin C in foods between harvesting and consumption is essentially a problem of preventing or reducing oxidation, either enzymatic or atmospheric. In addition, physical or solution losses must be minimized in preparation of the food for the table. It is pertinent to note that modern commercial canning procedures are well adapted to control both these chemical and physical losses of vitamin C (3).

The use of prime raw stock and quick transport to the cannery after harvesting; rapid inactivation of enzymes through heat treatment; and large scale automatic operations with minimal exposure to air, are basic practices common to all modern canning procedures. All serve to check oxidative losses of the initial ascorbic acid present in raw foods. In addition, during canning, the foods are cooked by the heat process while contained in the sealed can. The liquid within the can, therefore, retains vitamin C which has been removed from the food by solution.

Researches have shown that many commercially canned foods are to be listed among the most valuable contributors of vitamin C to the diet of the American people (2, 3, 4). Such findings demonstrate the effectiveness of modern commercial canning procedures in preservation to the highest practical degree of the initial vitamin C contents of foods.

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(1) 1932. Ztschr. f. Untersuch. d. Lebensmitt. 63, 1.
1933. J. Biol Chem. 103, 687.
(2) 1938. J. Amer. Med. Assn. 111, 1290.
(3) 1932. Ind. Eng. Chem. 24, 650.
(4) 1938. J. Amer. Med. Assn. 110, 650.
1937. Bull. 19-L Nat'l. Canners Assn., Washington, D. C., 4th Ed.

We want to make this series valuable to you, so we ask your help. Will you tell us on a post card addressed to the American Can Company, New York, N. Y., what phases of canned foods knowledge are of greatest interest to you? Your suggestions will determine the subject matter of future articles. This is the forty-fourth in a series, which summarize, for your convenience, the conclusions about canned foods reached by authorities in nutritional research.

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Radio Program: On the State Humane Pound Act.—The proposed initiative law No. 2 (State Humane Pound Act) had a place on the November 8, 1938, state election ballot. The measure was defeated by a more than two to one vote of the people. The proponents of the measure had the support of a large newspaper chain, its papers giving almost full-page display articles in favor of passage of the measure. In previous issues, in the editorial and other departments of CALIFORNIA AND WESTERN MEDICINE, appeared articles in which the campaign of the workers against the measure was outlined.

The educational work was largely centralized around the distribution of post-cards and literature. Here and there radio time was secured. The script of one of the radio hours, as put out by Mr. Stanley Cochems, Executive Secretary of the Los Angeles County Medical Association, has recently come into our possession. It is printed for its informative and suggestive value and should be of interest to all who may have occasion to use the radio networks in publicity work. The dialogue follows:

* * *

Music (Record): A few bars from "The Whistler and His Dog," including the whistling phrases, fading to the announcer.

Announcer: Everyone who has a spark of love within him loves his dog. Some of the world's most heroic acts might well be inscribed in bronze under a dog's name. Our dogs love us; they trust us implicitly; they expect us to protect them. In the interest of dogs and in the interest of humanity the following broadcast is dedicated. Mr. R. Allen Wilson, educator, and Mr. S. K. Cochems, representing one of Southern California's largest scientific organizations, will discuss Proposition No. 2, the Bill to Regulate Pounds. We present Mr. Wilson and Mr. Cochems.

Mr. Wilson: Just before we came in, Mr. Cochems, you said it was a pity that some sincere folks might vote "Yes" on Proposition No. 2, tomorrow. That is the so-called Humane Pound Act. You have two dogs and I have one, and we care a great deal for them. Don't you want them protected by this proposed legislation?

Mr. Cochems: I said it was a pity because I am very, very fond of dogs. I don't want them to suffer simply because a few misinformed or, rather, prejudiced individuals have stirred up a storm of emotionalism, and have done this, not to protect dogs, but to serve their own selfish pride, or their own selfish interests.

Proposition No. 2 is not a humane pound bill—it is an antivivisection measure fostered by drugless practitioners and others who are jealous of, or who deny the value of, scientific advance—who would stifle scientific research.

Proposition No. 2 would rob our dogs, as well as ourselves, of much of the merciful treatment now accorded to alleviate suffering.

Mr. Wilson: But I have been told that Proposition No. 2 was designed to do just what you say it will not do, that it would protect our pets from what has been pictured as inhumane treatment.

Mr. Cochems: My dog, Skippy, demonstrates what I mean. Skippy is a black Cocker Spaniel. A year ago I was out on the lawn with him. Skippy suddenly decided to run across the street. He dashed down the lawn, his long ears flopping—you know what a picture a Cocker makes when he is in a hurry—and Skippy was in a hurry. He didn't see the car that hit him . . .

As soon as my car slid to a stop in front of the veterinarian's office, Skippy's doctor ran to the curb and slipped a hypodermic needle somewhere into Skippy's hide. In ten seconds Skippy was asleep, completely under the effect of the anesthetic, nembutol!

If Skippy could know, he would be grateful for humane animal research. Thanks to nembutol, he was saved hours of excruciating pain while his doctor set the broken bones and formed the cast.

Nembutol and other products, made possible only by animal research, are used many times every day to relieve

(Continued on Next Page)

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(Continued from Preceding Page)

the suffering of animals as well as the suffering of human beings.

For this reason the Southern California Association of Small Animal Hospitals has gone on record opposing this proposition. Your dog's doctor should know what is good for your dog.

Mr. Wilson: You mean that without animal research anesthesia would not be available today? That is a statement of vital importance to every one of us. Then you mention "other products"—just what do you mean by that?

Mr. Cochems: There is not a single individual listening to us, Mr. Wilson, who does not have some fear of death by heart failure. There isn't a single listener who doesn't know of someone with heart trouble.

Have you ever witnessed a heart attack? That heart may be just fluttering—that person is very close to death. And then that product of scientific research—digitalis—is administered, and almost instantly that fluttering heart resumes its strong beating again. A life is saved for months and possibly years.

Digitalis is made possible only by animal research to test its potency before it may be administered. Proposition No. 2 would deny the countless thousands of heart sufferers the added years of life that now have been given to them.

Everyone who reaches the middle years of life knows a friend, a relative, who has diabetes. Proposition No. 2 would sign the death warrant for diabetics. Every batch of insulin—which is the one thing that allows the diabetic to live a normal life—must be tested—humanely, of course—upon animals to determine its potency. Proposition No. 2 would take insulin away.

Think of your friends, your relatives, or perhaps yourself in connection with insulin and diabetes, and you will vote "No" on Proposition No. 2, the antivivisection measure.

Mr. Wilson: As a dog owner, I have never found where a valued pet was in danger of being used for research.

I have owned three dogs that had to be put to sleep for their own good. In replacing them it was suggested that I might find a suitable pet at the pound. Upon looking over the dogs that could be released, there was not a single, well-kept pet in the lot; not a single dog that I would dare to take home.

This impressed me greatly with the fact that true dog lovers take care of their dogs. Desirable pets seldom reach the pound, or if they do by accident, are reclaimed within a few hours. Consequently, it seems to me that any of the animals taken from the pound to be used for scientific purposes are those which are undesirable. However, the proponents of Proposition No. 2 state that it will not hamper animal research, that it only forces research institutions to raise their own animals.

Mr. Cochems: That may be true if these institutions would not find it financially impossible to do this. But that is not the humane issue. Several thousands stray dogs are used each year for scientific—humane—investigation. These are strays that would be put out of the way if not so used. Is it humane to force breeding of the several thousand more dogs each year just to be used for animal research, while many thousands more than these will be killed regardless, and to no better purpose than to put them out of the way?

If Proposition No. 2 is defeated the educational and scientific organizations who have defeated it will seek by legislative enactment a true humane pound law, setting up a central information bureau in Los Angeles, where any pet owner may quickly get word of his lost pet, and providing that all dogs be kept at the pound more than seventy-two hours. That unclaimed strays be turned over only to accredited research and educational institutions.

Mr. Wilson: Can you clear this up, Mr. Cochems? I have read in certain of our daily papers that an eminent physician, a Dr. Wolf Adler, stated that animal research was no longer needed. Isn't he an authority?

Mr. Cochems: Absolutely not. This man Adler has talked a lot, and has been referred to as an eminent physician, as having been at one time connected with Bellevue Hospital in New York. Here is a wire from Dr. W. F.

Jacobs, Superintendent of Bellevue Hospital: Quote: "No record of Wolf Adler having been connected with Bellevue Hospital." End quote.

Adler's name is not in any directory of doctors of medicine. In a list of licentiates published in California, Adler's name appears under "Drugless Practitioners"; listed as a chiropractor. He appears to be the one so-called scientific authority cited by proponents of this proposition.

To refute his statements allow me to name only a few of the thousands of authorities who state that animal research is vital to the health of our people today, authorities who also state that Proposition No. 2 is an antivivisection measure.

A few of these authorities are Dr. Thomas Parran, Jr., Surgeon-General of the United States; Dr. Alexis Carrel, world-famous as a research worker of the Rockefeller Institute and author of the book, "Man the Unknown." Add to these names the names of the presidents of all of California's great universities, and it scarcely seems intelligent to balance the statement of one chiropractor against the analysis of these leaders who are attempting to protect the people of California from themselves.

Mr. Wilson: Sufficient evidence, certainly, Mr. Cochems, but I am still curious about one thing. Why have some of our newspapers given so much space in favor of Proposition No. 2 and presented pictures to indicate that animals are tortured? Here is a picture of a dog with a thumb screw devise in his mouth. That is graphic evidence, is it not, that dogs are tortured in the name of science?

Mr. Cochems: Graphic, indeed, Mr. Wilson, but not of torture. It is a very graphic picture of the steps the antivivisectionists will take in the name of propaganda.

But, first, only certain papers here and papers under the same ownership in San Francisco gave all this favorable publicity to this proposition. When pride or vanity is hurt, strange things may happen.

You read the October 24 issue of *Life*. Eight pages devoted to the antivivisection battle in California. You will recall that one page printed the pictures of Irene Castle McLaughlin and Marion Davies as the leading antivivisectionists, stating they supported Proposition No. 2. These pictures were followed by seven pages to illustrate the value of animal research. Under Marion Davies' picture, *Life* stated: "Actress Marion Davies is the most powerful antivivisectionist through publisher-friend William Randolph Hearst." That may answer part of your question, Mr. Wilson.

And here is the story of the dog and the thumbscrew gag. That dog is very old. The picture was printed twenty-five years ago. You may see that same dog today. Yesterday he was in the basement of the Bradbury Building—with the other horrors—the gag in his mouth. Stuffed! A stuffed dog—an example of a taxidermist's art plus the work, probably, of a Hollywood prop man who devotes his time to creating instruments for horror films.

Here is a new picture of that dog we took yesterday. You can see that the dog is stuffed. That picture was created solely for the purpose of attempting to make people believe that dogs are tortured in the name of scientific research.

When fanaticism needs propaganda, it appears that anything goes. Rather enlightening that their major argument is based upon deliberate deception in the name of humanitarianism.

Mr. Wilson: Mr. Cochems, aren't there any sincere people supporting this proposition? I mean people who know? It seems there have been many Hollywood names, celebrities, mentioned as urging the passage of Proposition No. 2.

Mr. Cochems: Not all of Hollywood. Louis B. Mayer of Metro-Goldwyn-Mayer, is a member of the executive committee, composed of California's most prominent citizens and educators, who are fighting this Proposition. They know it is especially dangerous to the health of the people of California.

You ask, Mr. Wilson, why certain motion picture stars are making personal appearances in favor of this Proposition. There are several reasons. Some of them are not so nice.

Publicity is life to a motion picture actor or actress. Publicity is obtained through the press. One special star has been mentioned. Now is the connection clear?

To accede to a request to appear in favor of this Proposition, if such a request comes from one high in the motion picture world, might logically be deemed to be the diplomatic thing to do. Dogs or babies be hanged.

And they are still talking, these motion picture actors and actresses. Some of them may be on the air tonight.

Have you seen the magazet called "The Tail Waggers?" A picture of a certain motion picture actor appeared in a recent issue. In the caption under it this actor is quoted as saying, "No one knows what true love and devotion is until he looks into the eyes of a dog."

It is said that many of them live with their dogs longer than they do with their wives.

Now, in all sincerity, there are many famous personages of the screen who are intelligent, who are highly educated, and who are scientifically minded.

These people will not lend themselves to the fostering of such pernicious legislation as is contemplated in Propo-

(Continued on Page 43)

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(Continued from Page 41)

sition No. 2, the antivivisection measure, and for them we have the highest respect.

For the others, some of whom may be speaking to you tonight, we trust that they are only misinformed; that some time they will realize that even in accepting publicity great harm may be done.

Mr. Wilson: From the information presented here this evening, Mr. Cochems, you have shown that science knows the remarkable discoveries and progress during the past few years through the aid of animal research, is only an indication of what will be accomplished for the benefit of mankind in the future; if science can continue its work unhampered.

Mr. Cochems: Right, Mr. Wilson, and don't forget that continued use of the various discoveries we accept as commonplace today is dependent entirely upon availability of animals for humane scientific research.

If you love your dog, if you love your children, if you have any love for humanity—then, in humanity's name, vote "No" on Proposition No. 2, tomorrow.

(Music—From the "Whistler and His Dog," fading out to station announcement.)

Industrial Laboratories and Clinical Research.*—What E. R. Squibb and Sons have undertaken, in the creation of this laboratory, illustrates a modern point of view of industry, involving more appreciation than formerly of social responsibility, and readiness to devote some part of earnings to the welfare of society. The development of this point of view, as I shall emphasize, is good insurance, indeed I may say necessary insurance.

Drs. William and Charles Mayo, talented as surgeons, and fortunate in environment and time, were so successful financially in the early years of their practice in Rochester, Minnesota, that they easily could have amassed large fortunes. Instead, they set aside from their earnings any sums in excess of what was necessary to provide circumstances of living favorable for their work, and later when they assembled a staff of physicians to share their labors, they themselves and the members of the staff received salaries, while all accumulations over and above these and other necessary expenses continued to be set aside with the definite purpose from the beginning of returning such money to the sick whence it came.

The motive was a desire to contribute as largely as possible to human welfare, combined with appreciation of danger inherent in the private possession of wealth. They expressed the belief that wealth frequently encourages waste of time and changes objectives in life; that it often takes away from sons and daughters the desire to labor and achieve, and introduces distractions whereby instead of developing into useful citizens the younger members of affluent families sometimes become dissolute.

How to restore to the sick the money which had grown by fortunate investments of sums collected as fees, then amounting to a million and a half dollars, was decided upon in 1913. In that year they gave the entire amount to the University of Minnesota to establish The Mayo Foundation for Medical Education and Research. The same policy continues. Relatively modest salaries are received by the members of the staff of The Mayo Clinic, salaries comparable to those paid by universities; running expenses are met and the balance is returned to the sick through The Mayo Foundation, in the form of advanced medical education for developing better-trained physicians, and as laboratories for research.

By older rules the procedure of the Doctors Mayo would be regarded as poor, if not suicidal, business practice; but standards are changing and that the older rules were not infallible is indicated by the continuing success of the enterprise conducted by the Mayos. Also that the profit motive, which must actuate private business enterprise, is not

(Continued on Page 45)

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* Address of Dr. Russell M. Wilder, Ph.D., M.D., of the Department of Medicine of The Mayo Foundation, Rochester, Minnesota, which was delivered at the ceremony dedicating the Squibb Institute for Medical Research, New Brunswick, New Jersey, on Tuesday, October 11, at 1 p. m.

Points and Views on the SERUM THERAPY OF PNEUMONIA

"Treatment of pneumonia has always been full of dangers. It has today, though new hopes exist, even more dangers. The dangers of delay in diagnosis, of incorrect typing, of sensitivity of patient, of overshadowing of other care by serum therapy, of failure to regard the disease as an emergency; all these dangers have been added."

—IRVING, NEW YORK STATE JOURNAL OF MEDICINE, JAN. 15, 1938.

"The traditional distinction between lobar and broncho-pneumonia is important as far as the niceties of accurate anatomical physical diagnosis are concerned. However, the etiological diagnosis is much more important since the intelligent treatment of the patient depends upon it."

—NEW YORK STATE JOURNAL OF MEDICINE, JAN. 15, 1938

"The effectiveness of serum therapy is multiplied by early administration and it is not wise to delay its use 'to see if it should become necessary.' A positive blood culture of Type 1 or Type 2 pneumococci renders serum therapy nearly obligatory."

—HINSHAW, JOURNAL-LANCET, AUGUST 1937.

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(Continued from Page 43)

irreconcilable with active support of public interests is shown by their exceptional example.

Other examples equally exceptional may be named, but I suggest that procedure like theirs will need to become the rule and not the exception if capitalism is to weather successfully the troubled times confronting us. Capitalistic democracy today is under fire as never before. Competing systems are established over a large part of the world, and the success of ours in promoting the public welfare will alone insure its continuance. Its most dangerous enemies are vain men who think their successes are owing exclusively to themselves, selfish men who demand much but give little, and stupid men out of touch with changing standards of morality and social-mindedness. Loud denunciation of other social systems can avail little to insure the success of ours. We shall be known only by our works.

It is especially important for the pharmaceutic industry clearly to perceive its responsibilities to the public, because the profits of this industry, like those of the profession of medicine, come from persons who because of loss of health are least able to contribute to profits. A considerable part of the cost of medical care which today is under public scrutiny goes for drugs and, as you know, much of this part is wasted; because frequently either the drugs are worthless, or they are not needed, or they are used improperly. To remedy these shortcomings of pharmaceutics and pharmacology is a clear responsibility of the pharmaceutic industry, but at this time I wish especially to emphasize the importance of doing all that can be done to promote a better understanding of the action of medicinal preparations through extension of facilities for research in therapeutics.

Medical science, in recent decades, has developed principally in laboratories of animal physiology, and in consequence what we have learned about dogs and rats exceeds what we know about ourselves. This is partly explained by the greater ease of experimentation on lower animals, but also responsible in part is the disproportionately larger provision made for research with animals. It is only in very recent years that American universities have admitted clinicians to their faculties, and in only a few universities where this has occurred is provision made for as rigid investigation of clinical material as the physiologist conducts with dogs.

The cynical Bernard Shaw, in his comedy "The Doctors' Dilemma," remarked that the only excuse for vivisection was that doctors were too stupid to learn what they needed to know by the study of man. No individual of his intelligence could conceivably minimize the importance of animal investigation unless he was misinformed, but we can learn from man more than we do learn and indeed we must learn more from him, because so much of the information obtained from other animals cannot apply to man.

I have in mind the striking differences between human diabetes and the diabetes of dogs after pancreatectomy. I think likewise of the distribution of potassium which in the human being is largely intracellular, and in the dog is divided more equally between the cells and the plasma of the blood, explaining, it may be, the unlike response to treatment of adrenalectomized dogs and patients with Addison's disease. Dissimilar also are the distributions of cholinergic and adrenergic nerve fibers in man and dog, accounting for sweating in the one and not in the other, and underlying, it may be, species differences in susceptibility to toxins and drugs.

However, as was intimated by Mr. Shaw, research on man demands more and not less refinement of method, much more critical judgment and more rigid control. Otherwise the result is that of which we have had far too much already, extravagant theory, supported by imperfect observation, conducted under conditions which well-nigh exclude the possibility of scientific precision of observation.

What we require more of is the type of establishment represented by the Rockefeller Hospital in New York, in which the physician is also a disciplined investigator, nurses and technicians are trained in scientific methods, and patients who volunteer to be subjects of research can be maintained without expense to themselves as long as is

(Continued on Page 48)

A Business HYPODERMIC

THE revival of business is largely dependent upon forward-looking business men with faith and vision. Lack of confidence, reflected by curtailment of advertising and printed matter, is easily sensed by the buying public. Business men no longer can lay the onus to the consumer—it is up to them to lead the way.

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(Continued from Page 45)

desirable from the standpoint of the research involved. Less pretentious, but similarly effective, are the Thorndike Laboratories in the Boston City Hospital, and a very few other similar research units within other hospitals. It is almost hopeless, as all with experience will agree, to obtain rigid control of investigations conducted in the wards and rooms of general hospitals. Scientific nursing and closely approximated special laboratories are indispensable for this type of research.

What I am urging is not an extension of facilities for the clinical observation of patients. Abundant provision already has been made for this purpose and skillful physicians are numerous. The need is for laboratories of clinical research where problems involving human therapeutics can be attacked with a precision of method equal to that in which the biologist is disciplined, and where the research is undertaken by men possessing training both in biology and medicine.

Few physicians have acquired the scientific discipline demanded for such research. This accounts for the lack of repute as scientists in which many of us are held by colleagues in the so-called fundamental departments, but likewise few biological chemists or physiologists, lacking clinical experience, are able to envisage problems involving therapeutics with the dispassioned judgment to be expected of them from their scientific tutelage. This is common knowledge; however, investigators who are adapted for critical studies of the type we require can be found in sufficient number when places for them are provided.

Among the younger physicians of today are many who, before or after completing their medical education, have been trained in physiologic or biochemical investigation. The fact is demonstrated every year by the program of the American Society for Clinical Investigation and that of the Central Society for Clinical Research. What such men need to accomplish the most of which they are capable are full-time positions which carry some assurance of security, more relief than they now have, in most cases, from the

(Continued on Page 50)

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(Continued from Page 48)

exacting and time-consuming responsibility for the care of patients, and scientifically trained nursing and technical assistance.

Research on man, I am glad to learn, is a part of the program of work contemplated by the Squibb Institution for Medical Research, through its Division of Experimental Medicine. A hospital affiliation is proposed whereby a free ward of fifteen to twenty beds will be maintained for the study of problems involving therapeutics. The field, I suggest, is one that the pharmaceutic industry might enter with great advantage.

With suitable endowments many institutes like the Thorndike Laboratories could be organized. I should like to see them located in university hospitals because only in hospitals which are integral parts of universities is the environment all that is necessary. In no place else can the clinical investigator obtain guidance from scientists on the one hand and criticism from clinicians on the other. He requires both, the former to hold him to the discipline of science, the latter to maintain the reliability of his clinical judgments.

The establishment and maintenance of the institutions proposed will involve the expenditure of considerable sums of money. On the other hand, undoubtedly they will return what is invested a hundredfold. The achievement of the Thorndike Laboratories in the treatment of anemia and that of the Rockefeller Hospital in the treatment of pneumonia are illustrations of such returns. Neither of the investigations on which these discoveries depended could have been conducted in the wards of a general hospital or under circumstances less favorable than can be provided by the kind of institution I am urging you to develop.

In promoting this type of research, or for that matter in its support of research of any variety, industry must not make the mistake of expecting "Nobel" prizes. Work of quality should be demanded, but nothing more. Important discoveries, like those I have named, may or may not re-

(Continued on Page 52)

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(Continued from Page 50)

ward the most persistent effort. Science is a proud mistress who bestows her favors jealously, even to men who court her nobly. She resists coercion; her smiles are not for sale, and the scientist, like the artist, rarely achieves outstanding success unless he is permitted to follow his own inspirations wherever they may lead.

There is an old saying that "big money makes for bad art" and certain it is that patrons of science, like those of art, obtain more for their money when they avoid dictation. Particularly will it be important to exclude commercial considerations from laboratories depending for their support on the contributions of industry; otherwise, much will be lost, since suspicion then will attach to whatever results are obtained, and men of scientific integrity will be repulsed. Concern for human welfare should be the only motivator of endowments such as these.

Thus in offering my congratulations to E. R. Squibb and Sons for the undertaking which we now are dedicating,

(Continued on Page 54)

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(Continued from Page 52)

I hope that their interest in endeavor of this kind will lead to other contributions, with particular reference to the need for more research in the field of therapeutics, and finally that the projects they do promote will always be inspired primarily by concern for human welfare.

State of California: Department of Industrial Relations.—Excerpts from a recent report to Governor's Council follow: Division of Immigration and Housing—During the month of October, 127 labor camps were inspected and 24 reinspected; 46 camps were listed as good; 67 fair and 14 bad. In the camps inspected it was found that 3,386 occupants were American-born, while 2,638 were foreign-born, making a total of 6,069, of which 2,683 were men, 1,225 women and 1,478 children.

During the month, 40 auto camps were inspected and 21 reinspected; 9 were listed as good, 17 fair, 4 bad and 10 closed. Seven trailer camps were inspected and 1 reinspected; one was listed as good, 3 fair, 2 bad and 1 closed.

One hundred and sixteen housing inspections were made; 3 were found to comply with the rules; 91 did not comply and 22 were under construction; 62 reinspections were made, in which 27 were made to comply with the rules and 35 cases pending.

During the strike in the cotton fields in Kern County the inspectors spent a good deal of time patrolling the affected area—contacting employers and employees in an effort to keep the camps up to the required standard. This work was important, but reduced the number of individual camp inspections appearing on the record.

The influx of thousands of workers and their families to the Kennett Dam area has brought about a serious situation respecting shack dwellings and general sanitation and, upon the recommendation of this Division, Shasta County has recently adopted our model squatter camp ordinance which bans the latter type of camps and embodies regulations for other camps that are not already subject to state laws. The ordinance has done much good in the counties where it is in operation and its preparation and distribution throughout the state was with the thought in mind that if this Division could not itself regulate camps under existing statutes it could put into the hands of county officials a complete ordinance draft for local enforcement.

The Division was called upon for aid in cleaning up insanitary housing conditions that existed in the City of Santa Cruz. Some of the places were found to be unfit for human habitation and have been ordered vacated or demolished.

At Gilroy, in a combination apartment house and hotel, under construction, many violations of the statute were found to exist. These violations have been brought to the attention of both the owner and the City Council for corrections to meet the requirements of the statute. Reinspection will be made for compliance with our orders.

During the month we made a special investigation of the Filipino labor situation and housing conditions in the Santa Maria Valley for the United States Department of Labor and submitted report thereon to Washington.

The usual number of marital difficulties was filed. There was also routine work on naturalization and immigration questions—mostly among the Mexicans, Spaniards, Cubans and Italians.

The records show 39 complaints, 48 applications for assistance and 45 calls for information.

In 1937, 885 deaths from venereal diseases were recorded in this state, and in 1936, 807 such deaths were registered. Without doubt, the actual numbers of deaths due to venereal diseases were much greater. A large proportion of the deaths recorded as due to heart disease were, in reality, due to syphilis. It would seem that the time may be fast approaching when the true cause of death will appear upon the death certificates.

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Heart May Cause Indigestion Symptoms.—Flatulence and constipation may be forerunners of weakness in the heart, asserts Louis Faugeres Bishop, Jr., M.D., New York City, in his article entitled "Acute Indigestion—or Is It Heart Disease?" in the December issue of *Hygeia, The Health Magazine.*

Symptoms of an upset stomach which come on in later life when the heart is liable to accident may not be truly digestive. It is then the heart that is causing the stomach symptoms. Arteriosclerosis with high blood pressure is easily affected by digestive disturbances. In high blood pressure and heart disease one may have gas in the upper part of the abdomen together with tenderness and dyspepsia.

In coronary thrombosis there is frequently vomiting at the outset of the attack and a general feeling of distress which is often mistaken for "acute indigestion." In older persons acute indigestion, as such, is rather rare, because experience has taught them how to avoid foods that disagree with them.

The most commonly confused stomach-heart situation is that in which a clot has shut off the blood supply to the heart—coronary thrombosis. Should this supply be abruptly cut off, there is a tremendous shock to the whole body. Common symptoms may be not only the pain in the chest, and a sense of impending death or disaster but also nausea, vomiting and gas, just as you would feel if you had eaten some food that didn't agree with you.

These stomach symptoms overshadow the familiar symptoms and signs of shock: the cold and clammy skin, the sweating and the absence of pulse. But the ability to recognize the dread picture of coronary thrombosis in time would save many a valuable life which is lost by calling the attack acute indigestion.

The treatment of these heart attacks that masquerade as indigestion is absolute rest for the stomach and absolute rest for the heart. This means total abstinence from food for twenty-four hours, and this is difficult to enforce, because most people believe that food is necessary for life, and they won't take enough rest.

Anemia from Sulfanilamide.—Acute anemia occurred in twenty-one of 522 patients treated with sulfanilamide compounds by W. Barry Wood, Jr., M.D., Baltimore. His article on these cases is reported in *The Journal of the American Medical Association* for November 19.

The incidence was higher in children (8.3 per cent) than in adults (2.4 per cent). No definite predisposing factors were observed.

The earliest signs of the anemia appeared between twenty-four and seventy-two hours after the onset of treatment. They are as follows: (1) nausea and dizziness; (2) increased excretion of urobilin (brown urinary pigment) in the urine; (3) unexplained rise in temperature; (4) sudden drop in hemoglobin and, (5) hyperbilirubinemia (excess of red bile pigment) and jaundice.

The maximal anemia occurred usually on the fifth day, and in no case did it occur before the third or after the seventh day. The anemia is associated with acute hemolysis, but the pathogenesis is not known.

Four out of five patients in whom acute anemia had developed when first treated with sulfanilamide suffered recurrences when a second course of the drug was given.

The treatment of acute sulfanilamide anemia consists of two measures: (1) immediate withdrawal of the drug and (2) blood transfusion. Withdrawal of the drug in itself may not be effective, even when carried out early in the course of anemia. The response to blood transfusions has in all cases been satisfactory. There were no deaths.

San Francisco Fair Will Show "Microaquarium."—The spectacle of microscopic water organisms going through their daily routine of eating, resting and fighting is one of the unusual exhibits in the Hall of Science at the 1939 Golden Gate International Exposition. This unit, which is known as the "Microaquarium" is part of the zoölogical display of the University of California.

Drops of water containing the organisms will be placed on microscopic slides and through six projectors the microorganisms will be enlarged five hundred times and thrown

(Continued on Next Page)

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There are two units, The Colfax Hospital and the Bushnell Sanatorium, for the treatment of Pulmonary Tuberculosis.

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(Continued from Preceding Page)

onto screens where their slightest movements may be seen by onlookers. The spectator will even be able to see the breathing of the organism and many of the mysteries of the cycle of life within water. Technicians will be in attendance to explain various phases of this microscopic life.

As another portion of the zoölogical display there will be five units designed to reveal many of the mysteries of embryology or the factors of growth after creation. The first will show the embryology of the salamander Triturus, revealing how the structure portion known as the limb bud on one animal may be transplanted to another, so that the second animal will develop five limbs instead of four. The entire unit will be given over to the transposing or transferring of embryonic features from one group to another and from one individual to another in the salamander. It will show the embryo carrying over the pigmentation of the original animal to the second, and likewise developing organs of the original animal or animals in the new individual or species.

The second unit will reveal embryological features of the toad and the salamander particularly in regard to glandular control. The third unit will show embryological features of the tree frog or hyla and will be a study in the development of pigmentation. The embryological development of the chick and the rat, contrasting the bird and the animal, will next be shown with lantern slides detailing the technique of this experimentation and its results. The fifth unit will deal with the early embryology of the rabbit, showing changes that occur in the rabbit egg after fertilization.

Millions of visitors are expected to visit these displays during the 288 days of the World's Fair of the West.

Pneumonia is an important cause of deaths in infants. Out of 5,060 infant deaths in 1937, 745 were due to pneumonia and 685 to diarrhea and enteritis. Diseases peculiar to early infancy caused 2,256 deaths, and congenital malformation caused 476. More than half of all infant deaths last year were due to these two causes.

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Phosphorus as P......	2.62
Potassium as K.......	2.18
Calcium as Ca........	0.098
Iron as Fe...........	0.048
Magnesium as Mg....	0.13
Copper	0.00275
Manganese	Distinct Traces

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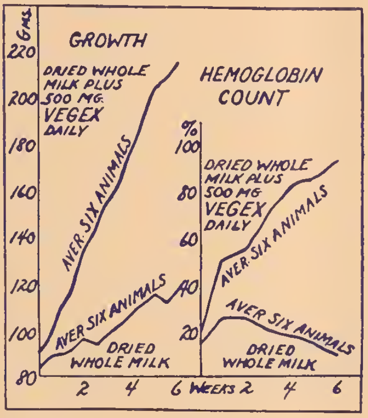

In the Newer Knowledge of Nutrition, 1923, McCollum and Simmonds say:

> "Possibly milk is lacking in both quantity and quality in substances necessary for adolescent growth and reproduction. The growth of rats on this ration and also on 5 per cent of yeast was normal."

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Five per cent of Vegex with dried whole milk does this job. The animals shown here are not "posed models" but an actual photograph of a male and female taken from a litter in the third generation fed with dried whole milk, five per cent of Vegex and water as the sole diet.

Our laboratories have not had full growth, nor reproduction with dried whole milk as the sole diet and, in all cases, there is a low red blood cell count. Chart I shows the growth curves using dried whole milk with and without Vegex, and the red blood cell counts. These curves and photographs cannot but compel attention.

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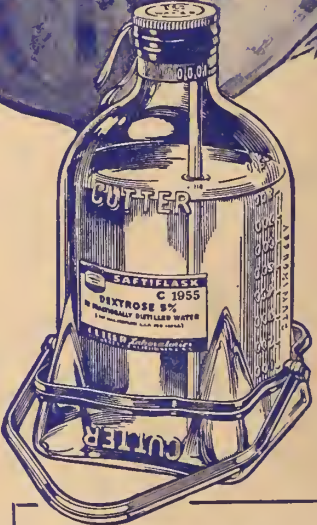

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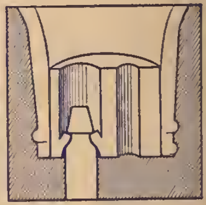

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Owned and Published Monthly by the California Medical Association
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"Entered as second-class matter at the post office at San Francisco, under the Act of March 3, 1879." Acceptance for mailing at special rate of postage provided for in Section 1103, Act of October 3, 1917, authorized August 10, 1918.

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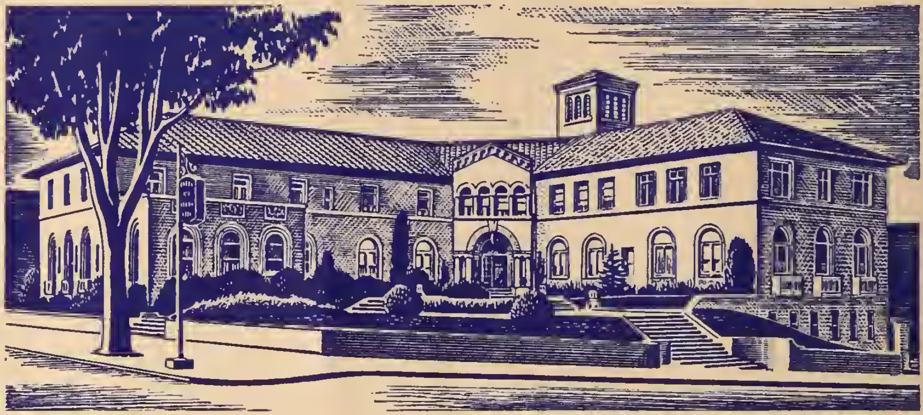

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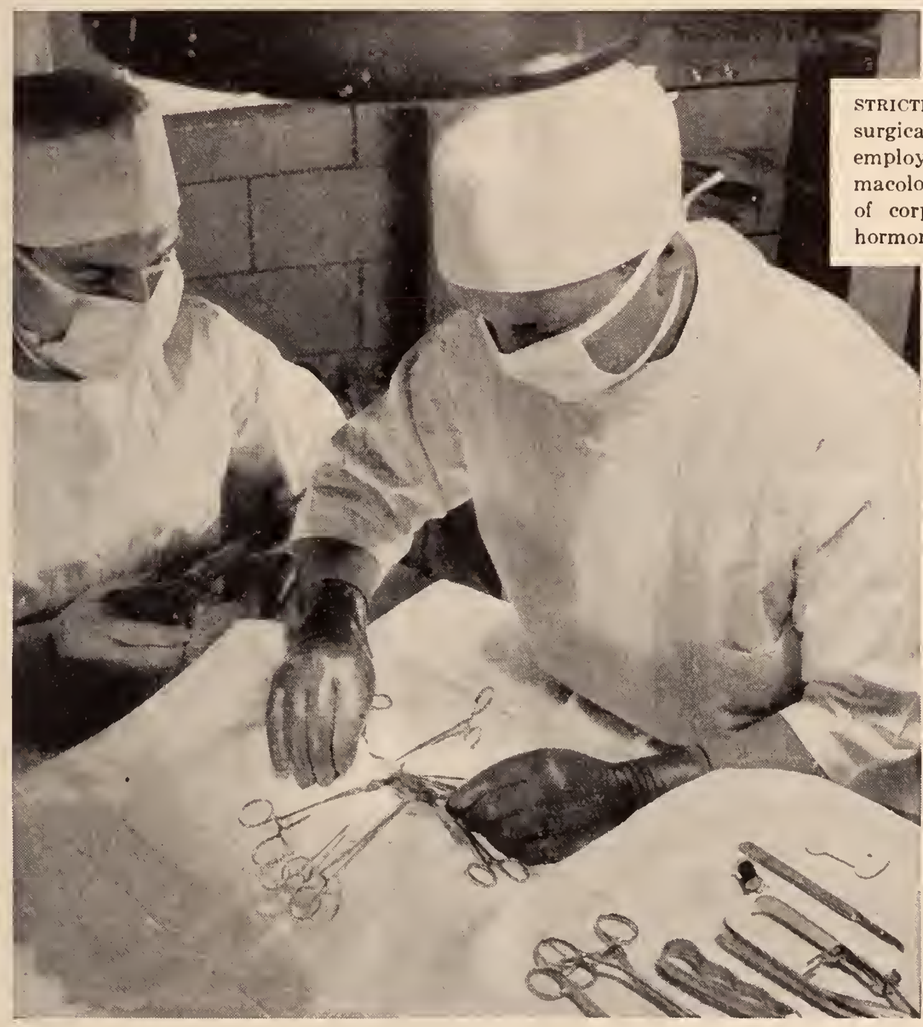

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John C. Ruddock (Chairman)	Los Angeles	1940
F. E. Clough	San Bernardino	1941

Secretary ex officio

Committee on Publications

Oscar Reiss	Los Angeles	1939
Ralph Eusden (Chairman)	Los Angeles	1940
Ruggles A. Cushman	Talmage	1941

Secretary ex officio
Editor ex officio

Committee on Public Policy and Legislation

T. Henshaw Kelly	San Francisco	1939
E. T. Remmen	Glendale	1940
Junius B. Harris (Chairman)	Sacramento	1941

President ex officio
President-elect ex officio

Committee on Scientific Work

F. M. Pottenger	Monrovia	1939
Lemuel P. Adams	Oakland	1940
J. Homer Woolsey	Woodland	1941

William H. Barrow, Secretary of Section on General Medicine, ex officio

Ray B. McCarty, Secretary of Section on General Surgery, ex officio

George H. Kress (Chairman), ex officio.

Committee on Public Relations

The Committee on Public Relations consists of the chairmen of the following standing committees and of certain general officers of the Association, all serving ex officio. The chairman of the committee is George G. Reinle, the secretary is George H. Kress. The director of the Department of Public Relations is George H. Kress. The chairman of the Committee on Public Relations is ex officio a member of the Council.

Fred B. Clarke	Chair., Com. on Health and Public Instruction
W. Earl Mitchell	Chair., Com. on Hospitals, Dispensaries, Clinics
Philip Stephens	Chair., Com. on Industrial Practice
George G. Reinle	Chair., Com. on Medical Defense
George D. Maner	Chair., Com. on Membership and Organization
John H. Graves	Chair., Com. on Medical Economics
Junius B. Harris	Chair., Com. on Public Policy and Legislation
Alson R. Kilgore	Chair., Cancer Commission
John C. Ruddock	Chair., Com. on Postgraduate Activities
William W. Roblee	President of California Medical Association
Charles A. Dukes	President-elect
George H. Kress	Secretary-Treasurer

Communications for the Public Relations Department should be addressed to the Director, George H. Kress, M. D., Room 2004, 450 Sutter Street, San Francisco.

Cancer Commission

Alson R. Kilgore (Chairman)	San Francisco	1939
Henry J. Ullmann	Santa Barbara	1939
Clarence G. Toland	Los Angeles	1939
Charles A. Dukes	Oakland	1940
Lyell C. Kinney (Vice-Chairman)	San Diego	1940
Otto H. Pflueger (Secretary)	San Francisco	1940
Orville Meland (Sec'y for Southern Section)	Los Angeles	1941
A. Herman Zeiler	Los Angeles	1941
Gertrude Moore	Oakland	1941

Communications for the Cancer Commission should be addressed to the Secretary, Otto H. Pflueger, M. D., Room 2004, 450 Sutter Street, San Francisco.

(Roster lists of officers of scientific section, component county societies, Woman's Auxiliary, A. M. A. delegates, special committees, etc., are continued on advertising pages 4 and 6.)

Decholin
REG. U.S. PAT. OFF.

In Chronic Cholecystitis

A True Choleretic
●
A Single Chemical Entity
●
Virtually Nontoxic

Through its intense choleretic influence, Decholin— c. p. dehydrocholic (triketocholanic) acid—steps up bile secretion by the liver cells as much as 200%. This intensified flow clears the biliary passages, lessens gallbladder tension, reduces absorption of toxic metabolites, improves gallbladder function, hastens recovery. To initiate choleresis more quickly, many physicians begin therapy with intravenous Decholin sodium (3 c.c. of the 20% solution), continuing therapy with Decholin 3¾ gr. tablets, one or two t. i. d. Physicians are invited to send for the second edition of the comprehensive brochure "Biliary Tract Disturbances."

ACCEPTED AMERICAN MEDICAL ASSN. Council on Pharmacy and Chemistry

Riedel-de Haen, Inc.
105 Hudson Street New York, N. Y.

Certification of Coal Tar Colors.—Secretary Henry A. Wallace recently announced that a hearing would be held February 6, 1939, on proposed regulations for the certification of coal-tar colors under the Federal Food, Drug, and Cosmetic Act. This newly enacted statute, which becomes effective June 25, 1939, prohibits the use of coal-tar colors in foods, drugs, and cosmetics unless the colors have been certified by the Department of Agriculture as harmless and suitable for use.

Listed in the proposed regulations are 132 coal-tar colors on which interested persons may submit testimony concerning harmlessness and suitability for use. Those who are unable to attend the hearing in person are invited to submit their testimony in affidavit form. The announcement points out, however, that the Secretary in the consideration of affidavits will be required to take into account the lack of opportunity for cross examination.

The list of 132 colors proposed includes the fifteen colors which have been certified for food use under the old Food and Drugs Act of 1906. The striking increase in the number of colors proposed is made necessary to meet the needs of drug and cosmetic manufacturers who have heretofore not required certified colors for use in their products.

The list of colors announced is not as comprehensive as manufacturers have requested. It has been impossible in the time available to make adequate investigations of the several hundred proposed. As investigations now under way are completed it is expected that additional colors will be proposed for listing.

A number of colors investigated were not included in the list because toxicological studies indicated that they are not harmless or because suitable methods of chemical analysis were not available. No color can be listed unless it can be analyzed for purity, Food and Drug officials explained.

The proposed regulations have been designed to offer consumers the greatest protection possible, within the authority of the statute, against harmful or unsuitable coal-tar colors. It is not proposed to certify any color for use in eyelash or eyebrow dyes.

ISOPHRIN
TRADE MARK REG. CALIF.

A non-irritating Neo-Synephrin Solution used as a nasal spray or drops

ISOPHRIN is ¼% Neo-Synephrin Hydrochloride in a special isotonic solution prepared only by Broemmel's.

Neo-Synephrin Hydrochloride is a synthetic substance of epinephrine-like action, but possesses the advantage that it is more stable, its effects are prolonged, and it does not irritate the nasal mucosa or cause sneezing.

Prolonged contact with certain metals may cause discoloration, therefore use spray bottles with only glass or hard rubber fittings.

Supplied in original bottles of 1 oz.

●

BROEMMEL'S PHARMACEUTICALS
FITZHUGH BUILDING
GArfield 4417 San Francisco, Calif.

ROSTER OF COUNTY MEDICAL SOCIETIES, CALIFORNIA MEDICAL ASSOCIATION

(County society secretaries are requested to promptly notify "California and Western Medicine" when changes are indicated in their roster information.)

Alameda County Medical Association
2404 Broadway, Oakland

President, Frank H. Bowles, 1624 Franklin Street, Oakland.

Secretary, Gertrude Moore, 2404 Broadway, Oakland.

Meeting, *Third Monday, 8:15 p. m., Hunter Hall, Oakland.*

Butte County Medical Society

President, E. L. Meyers, Fourth Street and Broadway, Chico.

Secretary, J. O. Chiapella, 131 Broadway, Chico.

Meeting, *Second Thursday.*

Contra Costa County Medical Society

President, Kaho Daily, 314 Tenth Street, Richmond.

Secretary, Clifford E. Dieterich, 1306 Pomona Avenue, Crockett.

Meeting, *Second Tuesday, 8 p. m.*

Fresno County Medical Society

President, Roland W. Dahlgren, 1006 Mattei Building, Fresno.

Secretary, Lester R. Nielson, 1006 Mattei Bldg., Fresno.

Meeting, *First Tuesday, University-Sequoia Club, Fresno.*

Humboldt County Medical Society

President, Samuel P. Burre, 507 F Street, Eureka.

Secretary, Joseph S. Woolford, 350 E Street, Eureka.

Meeting, *First Thursday.*

Imperial County Medical Society

President, Henry B. Graeser, 115 E. Fifth Street, Holtville.

Secretary, William A. Clarke, Holtville.

Meeting, *Third Tuesday, 7 p. m., Barbara Worth Hotel, El Centro.*

Kern County Medical Society

President, C. I. Mead, Haberfelde Building, Bakersfield.

Secretary, C. S. Compton, 428 C Street, Bakersfield.

Meeting, *Third Thursday, 8:00 p. m.*

Kings County Medical Society

President, P. K. Edmunds, Corcoran.

Secretary, William A. Johnstone, Hanford.

Meeting, *Second Monday, 8 p. m., Legion Hall, Hanford.*

Lassen-Plumas-Modoc County Medical Society

President, C. I. Burnett, Susanville.

Secretary, Fred J. Davis, Jr., Westwood.

Meeting, *On Call.*

Los Angeles County Medical Association
1925 Wilshire Boulevard, Los Angeles

President, William H. Daniel, 1930 Wilshire Boulevard, Los Angeles.

Secretary, George D. Maner, 1925 Wilshire Boulevard, Los Angeles.

Meetings, *First and Third Thursdays, 1925 Wilshire Boulevard, Los Angeles.*

Marin County Medical Society

President, Harry N. Hensler, Home Market Building, San Anselmo.

Secretary, Carl W. Clark, 510 B Street, San Rafael.

Meeting, *Fourth Thursday, 7:00 p. m., Marin Golf and Country Club.*

Mendocino-Lake County Medical Society

President, Robert B. Smalley, Willits.

Secretary, Dallas Wagner, Fort Bragg.

Meeting, *On Call.*

Merced County Medical Society

President, E. M. Soderstrom, Merced.

Secretary, Fred O. Lien, Shaffer Building, Merced.

Meeting, *Third Thursday, Hotel Tioga, Merced.*

Monterey County Medical Society

President, Walter P. Farr, 308 Main Street, Salinas.

Secretary, Herbert Archibald, Salinas National Bank Building, Salinas.

Meeting, *First Thursday.*

Napa County Medical Society

President, Alexander H. McLeish, Veterans Home Hospital, Yountville.

Secretary, M. M. Booth, Bruck Building, St. Helena.

Meeting, *First Wednesday.*

Orange County Medical Society

President, M. W. Hollingsworth, 1806 No. Main Street, Santa Ana.

Secretary, Glenn Curtis, 323 So. Pomona Street, Brea.

Meeting, *First Tuesday, 8 p. m., Chapel of the Orange County Hospital, Orange.*

Placer County Medical Society

President, William M. Miller, Auburn.

Secretary, Robert A. Peers, Colfax.

Meeting, *At Call of President.*

Riverside County Medical Society

President, N. K. Bear, 3655 Fourteenth Street, Riverside.

Secretary, Thomas A. Card, 3616 Main Street, Riverside.

Meeting, *Second Monday, 8 p. m., Library, Riverside Community Hospital.*

Sacramento Society for Medical Improvement

President, Manuel Azevedo, 1027 Tenth Street, Sacramento.

Secretary, Glenn E. Millar, 321 Physicians Building, Sacramento.

Meeting, *Third Tuesday, 8:30 p. m., Auditorium, Sacramento.*

San Benito County Medical Society

President, J. M. O'Donnell, Hollister.

Secretary, L. E. Smith, Hollister.

Meeting, *At Call of President.*

San Bernardino County Medical Society

President, Delbert B. Williams, 1151 D Street, San Bernardino.

Secretary, A. E. Varden, Medico-Dental Building, San Bernardino.

Meeting, *First Tuesday, 8 p. m., San Bernardino County Charity Hospital.*

San Diego County Medical Society
Fourteenth Floor, Medico-Dental Building, 233 A Street, San Diego

President, Hall G. Holder, 1109 Medico-Dental Building, San Diego.

Secretary, C. V. Bernardini, 1220 First National Bank Building, San Diego.

Meeting, *Second Tuesday, El Cortez Hotel.*

San Francisco County Medical Society
2180 Washington Street, San Francisco

President, Edwin L. Bruck, 384 Post Street, San Francisco.

Secretary, Stanley H. Mentzer, 2180 Washington Street, San Francisco.

Meetings, *Every Tuesday, 8:15 p. m., 2180 Washington Street, San Francisco.*

San Joaquin County Medical Society

President, N. P. Johnson, Medico-Dental Building, Stockton.

Secretary, George H. Rohrbacher, Medico-Dental Building, Stockton.

Meeting, *First Thursday, 8:15 p. m., Medico-Dental Club Rooms, Stockton.*

San Luis Obispo County Medical Society

President, J. B. V. Butler, 722 Marsh Street, San Luis Obispo.

Secretary, E. M. Bingham, County Health Department, San Luis Obispo.

Meeting, *Third Saturday, 6:30 p. m., Gold Dragon Cafe, San Luis Obispo.*

San Mateo County Medical Society

President, N. D. Morrison, 205 Third Avenue, San Mateo.

Secretary, J. Garwood Bridgman, 205 Third Avenue, San Mateo.

Meeting, *Fourth Wednesday, Benjamin Franklin Hotel, San Mateo.*

Santa Barbara County Medical Society

President, W. H. Johnston, 1515 State Street, Santa Barbara.

Secretary, D. H. McNamara, 317 W. Pueblo Street, Santa Barbara.

Meeting, *Second Monday, Cottage Hospital.*

Santa Clara County Medical Society

President, Cletus S. Sullivan, Bank of America Building, San Jose.

Secretary, Leslie B. Magoon, 652 East Santa Clara Street, San Jose.

Meeting, *Third Wednesday, 8 p. m., Medico-Dental Building, San Jose.*

Santa Cruz County Medical Society

President, John T. Harrington, 10 Cooper Street, Santa Cruz.

Secretary, Samuel B. Randall, 84 Walnut Avenue, Santa Cruz.

Meeting, *First Monday, 7:30 p. m., Club Rio del Mar, Aptos.*

Shasta County Medical Society

President, B. F. Saylor, Redding.

Secretary, Morton J. Murphy, 1542 Market Street, Redding.

Meeting, *Second Monday.*

Siskiyou County Medical Society

President, J. B. McGuire, Mt. Shasta.

Secretary, Victor W. Hart, 113 No. Oregon Street, Yreka.

Meeting, *Sunday on call.*

Solano County Medical Society

President, Ream S. Leachman, 727 Sonoma Street, Vallejo.

Secretary, John W. Green, Box 539, Vallejo.

Meeting, *Second Tuesday, 8 p. m., Casa de Vallejo Hotel, Vallejo.*

Sonoma County Medical Society

President, D. C. Oakleaf, 301A West Street, Healdsburg.

Secretary, T. E. Albers, 600 B Street, Santa Rosa.

Meeting, *Second Thursday.*

Stanislaus County Medical Society

President, John A. Cooper, 1024 J Street, Modesto.

Secretary, Hoyt R. Gant, 403 Beaty Building, Modesto.

Meeting, *Second Friday, 7:30 p. m., Hotel Hughson.*

Tehama County Medical Society

President, O. T. Wood, Red Bluff.

Secretary, R. G. Frey, Red Bluff.

Meeting, *At Call of President.*

Tulare County Medical Society

President, Newton Miller, 231 No. Main Street, Porterville.

Secretary, Ray Cronemiller, Exeter.

Meeting, *Sunday Evening once a month.*

Ventura County Medical Society

President, W. F. Mosher, 34 No. Ash Street, Ventura.

Secretary, A. A. Morrison, 625 Main Street, Santa Paula.

Meeting, *Second Tuesday, Ventura County Country Club.*

Yolo-Colusa-Glenn County Medical Society

President, H. G. Potter, Winters.

Secretary, W. J. Blevins, Jr., Woodland.

Meeting, *First Tuesday.*

Yuba-Sutter County Medical Society

President, P. E. Thunen, I. O. O. F. Building, Marysville.

Secretary, Leon M. Swift, I. O. O. F. Building, Marysville.

Meeting, *First Tuesday.*

(Roster lists continued on advertising page 6)

IS TASTE IMPORTANT?

STANDARD SIZE CONTAINS 16 FLUID OUNCES
Awarded Ten Gold Medals
Maltine
WITH
COD LIVER OIL
CONTAINS VITAMINS A, B, D and G IN NATURAL FORM
THE MALTINE COMPANY
NEW YORK

Maltine with Cod Liver Oil is especially prepared to avoid the unpleasant taste of the usual vitamin-bearing oils. Yet, it combines the recognized values of pure cod liver oil with those of a standardized medicinal malt extract, a combination which has been prescribed for more than two generations.

Maltine with Cod Liver Oil and Iron Iodide is also available, with two grains of freshly prepared iron iodide per fluid ounce. The Maltine Company, 21 West Street, New York City.

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WITH COD LIVER OIL

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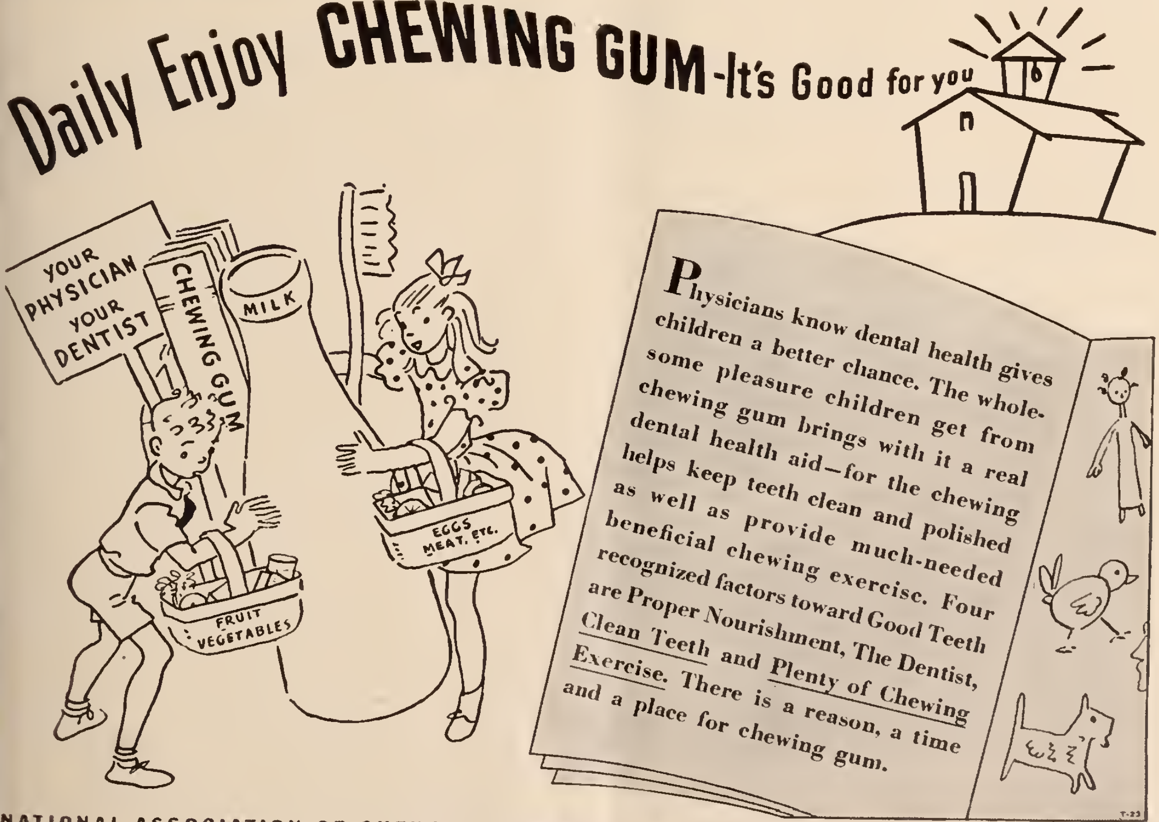
Daily Enjoy CHEWING GUM-It's Good for you
YOUR PHYSICIAN YOUR DENTIST
CHEWING GUM
MILK
EGGS MEAT, ETC.
FRUIT VEGETABLES
T-23

Physicians know dental health gives children a better chance. The wholesome pleasure children get from chewing gum brings with it a real dental health aid—for the chewing helps keep teeth clean and polished as well as provide much-needed beneficial chewing exercise. Four recognized factors toward Good Teeth are Proper Nourishment, The Dentist, Clean Teeth and Plenty of Chewing Exercise. There is a reason, a time and a place for chewing gum.

NATIONAL ASSOCIATION OF CHEWING GUM MANUFACTURERS, STATEN ISLAND, NEW YORK

OFFICERS OF SCIENTIFIC SECTIONS, CALIFORNIA MEDICAL ASSOCIATION

Anesthesiology

Chairman, John G. Dunlop, 168 So. Kingsley Drive, Los Angeles.
Secretary, Adena C. Dutton, 1955 Broadway, San Francisco.

Dermatology and Syphilology

Chairman, Norman N. Epstein, 450 Sutter Street, San Francisco.
Vice-Chairman, Franklin I. Ball, 6253 Hollywood Boulevard, Hollywood.
Secretary, Arne E. Ingels, 490 Post Street, San Francisco.

Eye, Ear, Nose and Throat

Chairman, Clifford B. Walker, 427 West Fifth Street, Los Angeles.
Vice-Chairman, Harry J. Wiley, 2701 Florence Street, Huntington Park.
Secretary, Dewey R. Powell, 242 No. Sutter Street, Stockton.

General Medicine

Chairman, Howard F. West, 602 Wilshire Medical Building, 1930 Wilshire Boulevard, Los Angeles.
Secretary, William H. Barrow, 1400 Medico-Dental Building, San Diego.

General Surgery

Chairman, Loren R. Chandler, Stanford University Medical School, San Francisco.
Secretary, Ray B. McCarty, 3616 Main Street, Riverside.
Assistant Secretary, Frederick S. Foote, 490 Post Street, San Francisco.

Industrial Medicine and Surgery

Chairman, Harvey G. McNeil, 523 West Sixth Street, Los Angeles.
Vice-Chairman, George H. Sanderson, 242 North Sutter Street, Stockton.
Secretary, John S. Stephens, 1136 W. Sixth Street, Los Angeles.

Neuropsychiatry

Chairman, John B. Doyle, 1930 Wilshire Boulevard, Los Angeles.
Secretary, George S. Johnson, Stanford University Hospital, San Francisco.

Obstetrics and Gynecology

Chairman, George W. Coon, 3770 Twelfth Street, Riverside.
Vice-Chairman, John N. Ewer, 411 Thirtieth Street, Oakland.
Secretary, William Benbow Thompson, 1930 Wilshire Boulevard, Los Angeles.

Pathology and Bacteriology

Chairman, Alvin G. Foord, Huntington Memorial Hospital, Pasadena.
Secretary, Roy W. Hammack, 657 South Westlake Boulevard, Los Angeles.
Assistant Secretary, Paul H. Guttman, 1127 Eleventh Street, Sacramento.

Pediatrics

Chairman, Harold K. Faber, Stanford Hospital, San Francisco.
Secretary, Hartzell H. Ray, 23 Second Avenue, San Mateo.
Assistant Secretary, W. W. Belford, 601 Medico-Dental Building, San Diego.

Radiology

Chairman, Karl M. Bonoff, 1930 Wilshire Boulevard, Los Angeles.
Secretary, Carl D. Benninghoven, Mills Memorial Hospital, San Mateo.

Urology

Chairman, Carl F. Rusche, 905 Taft Building, 1680 North Vine Street, Hollywood.
Secretary, John A. Dougherty, 3115 Webster Street, Oakland.

Delegates and Alternates to the American Medical Association

DELEGATES		ALTERNATES
Elbridge Best, San Francisco	(1938-1939)	Robert S. Stone, San Francisco
Lyell C. Kinney, San Diego	(1938-1939)	Bon. O. Adams, Riverside
J. P. Nuttall, Los Angeles	(1938-1939)	F. M. Pottenger, Los Angeles
George G. Reinle, Oakland	(1939-1940)	Frank R. Makinson, Oakland
Edward M. Pallette, Los Angeles	(1939-1940)	William H. Kiger, Los Angeles
Robert A. Peers, Colfax	(1939-1940)	F. F. Gundrum, Sacramento
William R. Molony, Sr., Los Angeles	(1939-1940)	John C. Ruddock, Los Angeles

Special Committees

Committee on Animal Experimentation

Philip Gilman, Chairman
Charles A. Dukes
Loren R. Chandler

Committee on Arrangements

Mast Wolfson, Chairman	Monterey
Alfred L. Phillips	Santa Cruz
W. M. Gratiot	Monterey
Curtis B. Gorham	Monterey
H. R. Lusignan	Monterey

Association Secretary ex officio

Committee on Maternal Welfare

T. Henshaw Kelly	San Francisco
Lyle G. McNeile	Los Angeles
Ralph J. Thompson	Los Angeles
T. Floyd Bell	Oakland
Hans F. Schluter	Sacramento

Committee on Golden Gate International Exposition

T. Henshaw Kelly, Chairman
Edward M. Pallette
Charles A. Dukes
Karl F. Meyer
Hartley F. Peart

Committee on Hospitals

Louis A. Packard, Chairman	Bakersfield
Axcel E. Anderson	Fresno
Calvert L. Emmons	Ontario

Committee on Syphilis

Howard Morrow, Chairman	San Francisco
Charles W. Barnett	San Francisco
William H. Goeckerman	Los Angeles

Committee on a Qualifying Certificate (Basic Science) Law

George H. Kress, (General Chairman)
San Francisco

Morton R. Gibbons, Chairman (for Bay Region), San Francisco

Edward M. Pallette, Chairman (for Southern California), Los Angeles

Junius B. Harris, Chairman (for Remainder of State), Sacramento

Woman's Auxiliary to the California Medical Association

State Auxiliary Officers

President, Mrs. Clifford A. Wright, 454 So. Irving Boulevard, Los Angeles.
President-Elect, Mrs. Frederick N. Scatena, 1400 Forty-first Street, Sacramento.
First Vice-President, Mrs. A. E. Anderson, 1035 Cambridge Street, Fresno.
Second Vice-President, Mrs. George Calvin, 277 Euclid Avenue, Oakland.
Recording Secretary, Mrs. G. Wendell Olsen, 219 Buena Vista Drive, Fullerton.
Corresponding Secretary, Mrs. E. Eric Larson, 126 Fremont Place, Los Angeles.
Treasurer, Mrs. Harry O. Hund, 400 Grand Avenue, San Rafael.

Officers of County Auxiliaries

Alameda County — President, Mrs. Frank Baxter, 33 Bowling Drive, Oakland.
Butte County—President, Mrs. N. T. Enloe, 488 East Third Street, Chico.
Contra Costa County—President, Mrs. Melvin A. Stauffer, Pittsburg.
Fresno County—President, Mrs. C. M. Vanderburgh, 518 Terrace Ave., Fresno.
Kern County—President, Mrs. P. N. Root, 2214 Cedar St., Bakersfield.
Lassen-Plumas-Modoc County — President, Mrs. G. R. Fortson, 912 Lassen Street, Susanville.
Los Angeles County—President, Mrs. William H. Leake, 609 North Palm Drive, Los Angeles.
Marin County—President, Mrs. Bernard J. Conroy, 402 Cascade Drive, Fairfax.
Merced County—President, Mrs. E. M. Soderstrom, 49 Twenty-second Street, Merced.
Monterey County — President, Mrs. Garth Parker, 430 So. Main Street, Salinas.
Orange County—President, Mrs. Hiram Currey, 2101 North Ross Street, Santa Ana.
Riverside County—President, Mrs. W. W. Roblee, 3117 Orange Ave., Riverside.
Sacramento County—President, Mrs. George Spencer, 1915 Twenty-first Street, Sacramento.
San Diego County—President, Mrs. Chester O. Tanner, 2454 Presidio, San Diego.
San Francisco County — President, Mrs. Thomas E. Gibson, 2205 Pacific Avenue, San Francisco.
San Joaquin County—President, Mrs. George K. Wever, 2413 Dwight Way, Stockton.
San Luis Obispo County—President, Mrs. Charles R. Kennedy, 1233 Olive Street, Paso Robles.
San Mateo County — President, Mrs. Carl Benninghoven, 140 Clark Drive, San Mateo.
Santa Barbara County—President, Mrs. H. E. Henderson, 1600 Oramus Road, Santa Barbara.
Santa Clara County—President, Mrs. M. D. Baker, 1142 Lincoln Ave., San Jose.
Santa Cruz County—President, Mrs. Alfred L. Phillips, 220 Escalon Drive, Santa Cruz.
Tulare County—President, Mrs. J. C. McClure, Box 36, Lindsay.

Miscellaneous California Medical Organizations

Department of Public Health of the State of California

San Francisco—State Office Building, McAllister and Larkin Streets, UNderhill 8700.
Sacramento—State Office Building, Tenth and L streets. CApital 2800.
Los Angeles—State Office Building, 217 West First Street. MAdison 1281.
President, Howard Morrow, San Francisco.
Director, Walter M. Dickie, State Building, San Francisco.

California Northern District Medical Society

President—John H. White, Chico.
Secretary—J. Homer Woolsey, Woodland Clinic, Woodland.

Board of Medical Examiners of the State of California

San Francisco, Room 214, 515 Van Ness Avenue.
Los Angeles, 906 State Building.
Sacramento, 420 State Office Building.
President, William R. Molony, Sr., Los Angeles.
Secretary, C. B. Pinkham, Room 214, 515 Van Ness Avenue, San Francisco.

Southern California Medical Association

President, John C. Ruddock, 1930 Wilshire Boulevard, Los Angeles.
Secretary, John B. Doyle, 501 Wilshire Medical Building, 1930 Wilshire Boulevard, Los Angeles.

The Public Health League of California

Executive Secretary, Ben H. Read. San Francisco office, 244 Kearny Street, Phone SUtter 8470, Los Angeles office, Room 563, 1151 South Broadway, Phone PRospect 5711.

Better Health Foundation

President, Reginald Knight Smith,* 490 Post Street, San Francisco.
Chairman, Executive Committee, Walter B. Coffey, 65 Market Street, San Francisco.
Treasurer, John Gallwey, 1195 Bush Street, San Francisco.
Secretary, Celestine J. Sullivan, 490 Post Street, San Francisco.

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* Deceased.

AN EFFECTIVE TREATMENT FOR
TRICHOMONAS VAGINITIS

effective treatment by Dry Powder Insufflation to be sup-
mented by a home treatment (Suppositories) to provide
ntinuous action between office visits. Two Insufflations,
week apart, with 12 suppositories satisfactorily clear up
large majority of cases.

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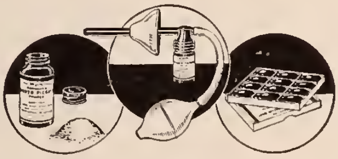

SILVER PICRATE — *a crystalline compound of silver in definite chemical combination with Picric Acid. Dosage Forms: Compound Silver Picrate Powder — Silver Picrate Vaginal Suppositories. Send for literature today.*

SILVER PICRATE • Wyeth •

Public Attitudes Toward Automobile Driving*—Problem: To sample the opinions, practices, and attitudes of the driving and nondriving public with regard to automobile driving and the problem of traffic safety.

Method: Personal interviews were made by advanced students in applied psychology at the University of Southern California. Each interview was conducted in a private home or apartment according to a pretested and standardized procedure.

A total of 450 interviews were conducted in the Los Angeles metropolitan area. Of these, 267 were with holders of operator's licenses, and the remaining 183 with persons not holding operator's licenses.

The sample was selected to give a true cross-section of the total population and was controlled for age, sex, and economic status, 68 per cent of our group had driver's licenses, a figure which checks closely with the estimate of 70 per cent given me by the Department of Motor Vehicles. This close check indicates that a true cross-section was obtained.

The methods used were those developed by the members of the Psychological Corporation of New York during the past five or six years and have been made known to the public through the Fortune Surveys, the Gallup Polls of Opion, and others.

Results:

Question 1: Does the law state that if a driver hits a pedestrian crossing the street against the signal the driver is always blameless?

(Asked of 267 licensed drivers) Yes, 26 per cent; No, 58 per cent; don't know, 16 per cent. Comment: It is quite clear that more than a fourth of our drivers must be taught that there is no such thing as "open season" on pedestrians.

Question 2: Do you sometimes make a left turn on the warning signal which comes before the Go signal?

(Asked of 267 licensed drivers.) Yes, 41 per cent; no, 55 per cent; don't know, 4 per cent. Comment: Do they do it because they do not know better or because they are willing to take a chance on not being caught? See the next question.

Question 3: Does traffic law in Los Angeles permit a driver to make a left turn on the warning signal which comes before the Go signal?

(Asked of 267 licensed drivers.) Yes, 12 per cent; no, 71 per cent; don't know, 17 per cent. Comment: This question makes it clear that the majority of offenders know the law, i. e., are willful offenders. The results of the two preceding questions indicate that driving practice deviates greatly from that defined by the law. This is an unsatisfactory condition which should be cleared up by changing the law or by strict enforcement of the regulation as it now stands.

Question 4: Should drivers found guilty of reckless driving have their cars plainly marked with a sticker?

(Asked of total sample of 450.) Yes, 70 per cent; no, 22 per cent; don't know, 8 per cent. Comment: Now is the time to try this suggested curb on the reckless driver, since sentiment is so clearly in favor of the plan.

Question 5: Should 10 per cent of the gas tax in California be spent for traffic-safety education and other definite safety purposes?

(Asked of total sample of 450.) Yes, 60 per cent; no, 19 per cent; don't know, 21 per cent. Comment: You can't have foolproof highways as long as you have fools on the highways and the public knows it: Let us spend some money showing people how to avoid being fools on the highway, says John Public.

The first thing to do in the presence of frequent colds is to determine whether there is any physical cause for their occurrence.—*Hygeia.*

---

* An analysis of the accident problem by Dr. Floyd L. Ruch, vice-chairman, California Safety Council; Associate Professor of Psychology, U. S. C.

From the California Safety Council, 1060 Mills Tower, San Francisco, DOuglas 5656; 427 West Fifth Street, Los Angeles, MIssion 9974.

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This coöperation will please the advertiser, increase advertising income, and enable your Association to increase the value of this Journal to members and readers.

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The Journal of the California State Medical Association and the Coöperative Medical Advertising Bureau of Chicago maintain a Service Department to answer inquiries from you about manufactured products, such as soaps, clothing, automobiles, etc., which you may need in your home, office, sanitarium or hospital, or we will refer your request to the proper department of the A. M. A. for reply.

We invite and urge you to use this Service. It is absolutely *free* to every member of the California Medical Association. The Coöperative Bureau is equipped with catalogues and price lists of manufacturers, and can supply you information by return mail.

Perhaps you want a certain kind of instrument which is not advertised in California and Western Medicine, and do not know where to secure it; or do not know where to obtain some automobile supplies you need. This A. M. A. Service Bureau will give you the information. Whenever possible, the goods will be advertised in our pages; but if they are not, we urge you to write direct to the Coöperative Medical Advertising Bureau, 535 N. Dearborn Street, Chicago, Illinois. California and Western Medicine and the A. M. A. Service Bureau desire to serve *you*.

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Proctology
Neurology
Cystoscopy and Endoscopy
Dermatology and Syphilology
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Roentgenology
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A full-time course. In Obstetrics: Lectures; prenatal clinics, witnessing normal and operative deliveries; operative obstetrics (manikin). Gynecology: Lectures; touch clinics; witnessing operations; examination of patients, pre-operatively; follow-up in wards post-operatively. Obstetrical and Gynecological pathology. Regional anesthesia (cadaver). Attendance at conferences in Obstetrics and Gynecology. Operative Gynecology on the cadaver.

FOR INFORMATION ADDRESS
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MEDICINE—Personal Courses and Informal Course starting every week. Two Weeks Course in Internal Medicine, starting June 5, 1939.
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GYNECOLOGY—Two Weeks Course starting February 27, 1939. Clinical and Personal Courses starting every week.
OBSTETRICS—Two Weeks Intensive Course starting March 13, 1939. Informal Course starting every week.
FRACTURES AND TRAUMATIC SURGERY—Informal Course every week; Intensive Ten-Day Course starting February 13, 1939.
OTOLARYNGOLOGY—Two Weeks Intensive Course starting April 10, 1939. Informal Course starting every week.
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●
TEACHING FACULTY — ATTENDING STAFF OF COOK COUNTY HOSPITAL
Address: Registrar, 427 South Honore Street, Chicago, Ill.

Syphilis Control in American Colleges.—Syphilis control and education in American colleges is a real problem, Dr. Raymond A. Vonderlehr, Assistant Surgeon General in charge of the Division of Venereal Diseases, United States Public Health Service, recently told the annual meeting of the American Student Health Association at the Hotel New Yorker in New York City. In Doctor Vonderlehr's opinion, this problem can best be solved by a concerted coöperative effort of college physicians, students, and the states.

"In large measure," Doctor Vonderlehr said, "college authorities realize that there is necessity for fighting syphilis on every front, including the college campus. . . ."

Doctor Vonderlehr drew attention to the recently published "Study of Syphilis in American Colleges" by staff members of the Division of Venereal Diseases of the United States Public Health Service, and pointed out that on the basis of 78,388 blood tests, the largest sample yet taken among college students, the prevalence of syphilis among white college students is 19.9 per 10,000, and is not significantly different from the rate for the comparable group in the general population. The rate for Negro students, 268 per 10,000, also is comparable with that for the general Negro population of a corresponding age-group and the slightly lower rate among college women is in line with the national figures. Size of enrollment, type of institution, or geographic location has no bearing on the rate of syphilis, which is constant at approximately two per 1,000 in all cases for white students.

Doctor Vonderlehr pointed out, however, that much syphilis among college students is not found by methods at present in use. "Failure to detect the hidden manifestations of syphilis is frequent," he said. "Many infected persons do not know that they have syphilis, and therefore they do not request examination. The consequence is that testing by selective (voluntary) methods results in failure frequently to detect syphilis among college students."

While Doctor Vonderlehr reported that 40 per cent of the 515 institutions surveyed have facilities already in operation, most of these test on clinical indication, or at the request of the student. Only twenty-three schools test routinely. . . .

Discussing the question of whether the college student, until now considered to be a minor factor in the syphilis control problem, should be offered anything more than an educational program, Doctor Vonderlehr said, "It is not to be denied that there are other youth groups in our population in which the problem is more serious, or to whom the means of combating the disease are not so easily available. . . . But, in fact, there exists a direct connection between the medical problem in the schools and colleges and in other youth groups. The connecting link is the educational and demonstrative value of college programs." . . .

Considering educational aspects of the syphilis problem in the colleges, Doctor Vonderlehr held that "no one will claim that matters of sex education, of the venereal diseases, of preparation for marriage and parenthood have been more than touched upon. In too many of these subjects there exists a yawning chasm in our curricula.

"For at least one of these subjects the reasons mitigating against a frontal attack have been largely removed. We now know syphilis to be a problem in the colleges. We know we can control it by applying modern public health principles. We know that if we do, public opinion will support that action, and we must realize that colleges have a responsibility to take the lead in the field of education. Certainly, until the colleges recognize subjects such as syphilis and other venereal diseases to be valid topics of instruction, we can hope for little advance in secondary schools."

Doctor Vonderlehr recommended that "instruction in the venereal diseases should be included in the usual course on the control of communicable diseases. It should also have a proper place in any course dealing with sex education, hygiene, and public health. Syphilis may well be used to illustrate a modern community health program with emphasis upon health education."

Medical control problems were outlined by Doctor Vonderlehr. The routine blood test, he pointed out, offers the

(Continued on Next Page)

HOSPITALS AND SANATORIUMS

The Institutions here listed have announcements in this issue of CALIFORNIA AND WESTERN MEDICINE. For Index, see advertising page 8.

ALUM ROCK SANATORIUM
For Treatment of Diseases of the Chest
San Jose, California

CALIFORNIA SANITARIUM
For Treatment of Tuberculosis
Belmont, California

CANYON SANATORIUM
For Treatment of Tuberculosis
Redwood City, California

CEDAR LODGE
For Treatment of Alcoholic and Narcotic Addiction Diseases
2030 Griffith Park Boulevard, Los Angeles

COLFAX SCHOOL FOR THE TUBERCULOUS
For the Treatment of Tuberculosis
Colfax, California

COMPTON SANATORIUM AND LAS CAMPANAS HOSPITAL
Neuropsychiatric and General
Compton, California

FRANKLIN HOSPITAL
Limited General Hospital
Fourteenth and Noe Streets, San Francisco

FRENCH HOSPITAL
General Hospital
Geary at Fifth Avenue, San Francisco

GREENS' EYE HOSPITAL
Consultation, Diagnosis and Treatment of Diseases of the Eye
Bush and Octavia Streets, San Francisco

LAS ENCINAS SANITARIUM
Nervous and General Diseases
Las Encinas, Pasadena, California

LIVERMORE SANITARIUM
Nervous and General Diseases
Livermore, California

OAKS SANITARIUM
For Treatment of Tuberculosis
Los Gatos, California

POTTENGER SANATORIUM AND CLINIC
For the Treatment of Tuberculosis
Monrovia, California

PARK SANITARIUM
Mental and Nervous Alcoholic and Drug Addictions
1500 Page Street, San Francisco, California

SAINT FRANCIS HOSPITAL
Limited General Hospital
Bush and Hyde Streets, San Francisco

ST. LUKE'S HOSPITAL
Limited General Hospital
27th and Valencia Streets, San Francisco

ST. MARY'S HOSPITAL
General Hospital
2200 Hayes Street, San Francisco

TWIN PINES
Convalescent and Neuropsychiatric
Belmont, California

BELMONT **Twin Pines** CALIFORNIA
Fatigue states, neuroses, and selected mental cases.
ALLEN WILLIAMS, M. D. *Internal Medicine*
Telephone BELMONT 111
WILL REBEC, M. D. *Psychiatry*

(Continued from Preceding Page)

most practicable method of finding syphilis quickly, easily, and cheaply. Little or no addition to personnel required for complete physical examinations of entering students is required, and coöperation with state or municipal laboratories will reduce costs to a negligible figure.

Once found, syphilis can be cured. In handling these positive cases, however, the Health Service official stressed three points:

"1. Obviously, it is of extreme importance to be sure the positive report is indicative of syphilis. Competent laboratories usually run several tests on blood specimens, but even their positive reports should be verified by physical examination and a second positive blood test in patients with latent syphilis.

"2. It is very important that the physician see to it that treatment is begun and carried through. By whom the treatment is to be given is a matter for individual decision. In many cases it may be possible for the student to take treatments from his own physician or pay for such treatments himself. If he cannot, however, the school must see that treatments from some source are forthcoming.

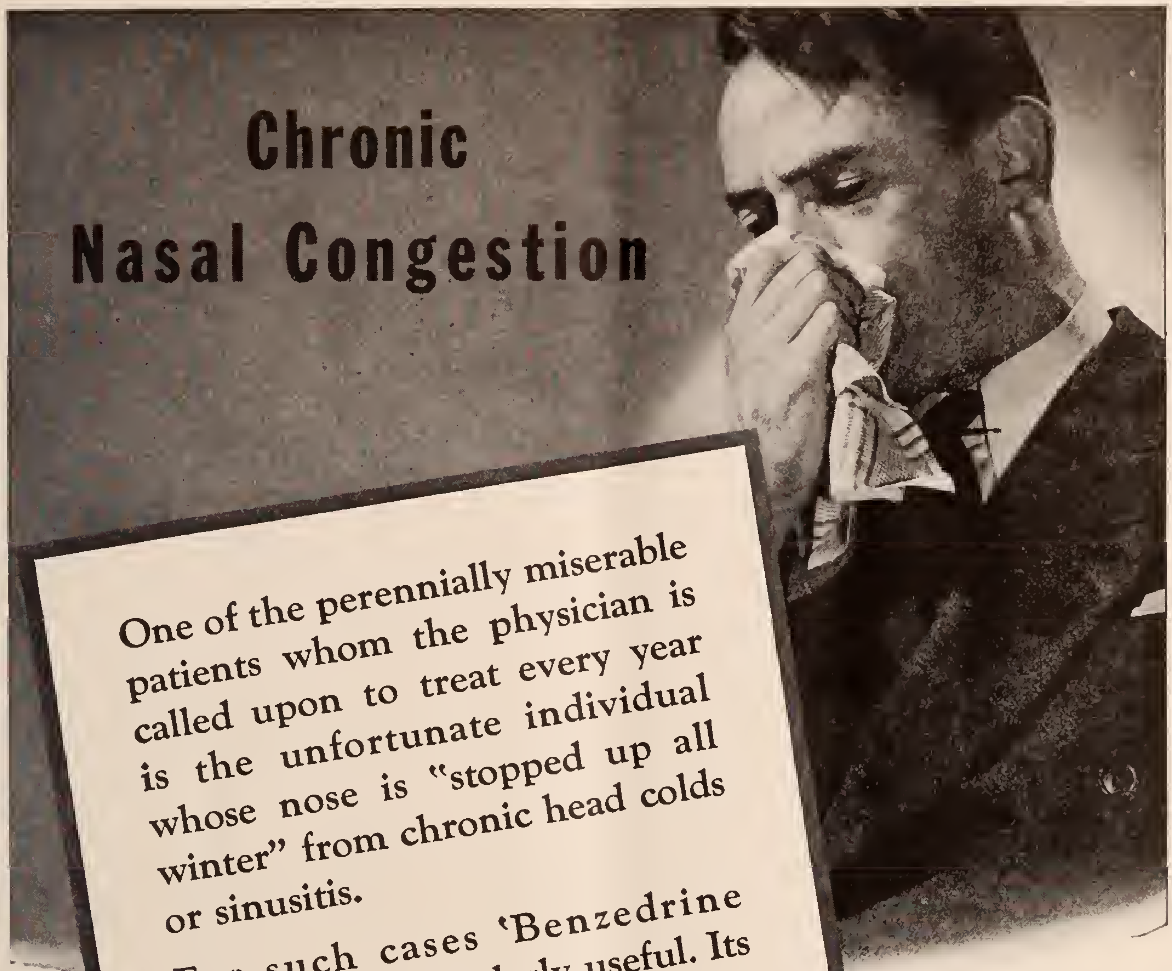
"3. Closely linked to this problem of treatment is a third point: Positive reactions must not be allowed to be the basis of expulsion or other disciplinary action unless the patient refuses to carry through adequate treatment or persists in activity conducive to the spread of the disease."

If one continues to ply one's mind, growth ensues, even in the years formerly supposed to be marked by stagnation and decay. To foster this growth one must not trust too much to the casual gains of every day work and experience. One must put forth well directed efforts. Merely to maintain one's status is not enough. He who is satisfied to stand still will soon slip backward. To grow one must go on learning. So it has come about that education, formerly thought to be an activity limited to the days of one's youth, is now seen in one form or another to be desirable in all periods of life. Thus one continues to improve; thus one keeps young.—Leon J. Richardson.

Art Tells History of American Medicine: "Beaumont and St. Martin."—"Beaumont and St. Martin" is the first of six large paintings in oil, memorializing "Pioneers of American Medicine," which artist Dean Cornwell will complete in the next few years. Others in the series are: Dr. Oliver Wendell Holmes, Dr. Ephraim McDowell, Dr. Crawford W. Long, Dr. William T. G. Morton, and Major Walter Reed, and one woman, Dorothea Lynde Dix, who, while not a physician, stimulated physicians to study insanity and feeble-mindedness.

Arrangements to supply physicians with free, full-color reproductions of "Beaumont and St. Martin" without advertising, and suitable for framing, have been made with the owners, John Wyeth & Brother, 1118 Washington Street, Philadelphia.

Sound, produced by the action of the breath on the vocal cords, is the raw material of speech.—*Hygeia.*



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For such cases 'Benzedrine Inhaler' is particularly useful. Its vapor diffuses through the nasal cavity, relieves congestion and aids in establishing ventilation.

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Each tube is packed with amphetamine, S.K.F., 0.325 Gm.; oil of lavender, 0.097 Gm., menthol, 0.032 Gm.

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NORTHERN CALIFORNIA PRACTICE AND EQUIPMENT for sale. Here only one year but collections $5,600. Wish to take some postgraduate work. Invoice over $2,000. Fine climate and hunting and fishing. Will take $1,000. Write, Box 200, c/o California and Western Medicine, 450 Sutter Street, San Francisco, Calif.

WANTED, BY PHYSICIAN LICENSED IN CALIFORNIA— position as assistant or associate to general practitioner or institution, in out of town practice. Ten years' experience in Germany. Address Box 210, California and Western Medicine, 450 Sutter Street, San Francisco, California.

Golden Gate International Exposition: "Heart Glucosides in Medicine."—The Sandoz Chemical Works, Inc., Basle, New York, will show the results of the distinguished chemist, Prof. Dr. Arthur Stoll, and his collaborators, especially with reference to the isolation of the cardiac glucosides actually preëxisting in the fresh plant. This work made possible their individual study, and the elucidation of their relationships to previous isolated glucosides now shown to be degradation products.

These investigations cover different fields of chemical, pharmacological and medical research, and serve to illustrate the fact that chemical discoveries of theoretical interest may have important practical application in medicine. In addition, there will be shown the importance of the different classes of glucosides: the cardiac glucosides and the sugars; digitalis and squill glucosides; the strophanthins; the sapinin glucosides; the toad venoms; the glucosides of digitalis lanata; the isolation of digilanid and its separation into individual components; the graded hydrolysis of the digilanids; the genuine glucosides of digitalis purpurea and the results of the comparative pharmacological investigations of the glucosides.

There will be shown also the flowering plants of the various species of digitalis, squill, and strophanthus; chemically pure crystalline substances derived from these plants, and the finished products. These will be further illustrated by formulae, curves, and charts. During the entire duration of the exhibit, interesting films will be shown on various aspects of heart disease.

Exhibit material prepared through the resources of the California Heart Association will also be shown and it will include the significance of the heart and its diseases, diagnosis and treatment.

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Exploitation of the Medical Profession.—Everywhere it is rampant—newspapers, magazines, billboards, radio. "Your doctor will tell you that. . . ." "Medical science has found that. . . ." "The greatest specialists in Timbuctoo say that. . . ." And the rest of the story is, of course, "Use our pills or our vitamins three times a day; ask your doctor."

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It has been said that ten more years of the present trend of interference in medical practice will do away with the need for private practice of infant feeding and other branches of medicine.

Mead Johnson & Company have always believed that the feeding and care of babies and growing children is an individual problem that can best be controlled by the individual physician. For over twenty years and in dozens of ethical ways we have given practical effect to this creed. We hold the interest of the medical profession higher than our own, for we too, no doubt, could sell more of our products were we to advertise them directly to the public.

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INA M. RICHTER, M. D., *Medical Director* JOHN A. ROBINSON, *Senior Master*

BOOKS RECEIVED

Consultation Room. By Frederic Loomis, M. D., Diplomate of the American Board of Obstetrics and Gynecology, Oakland, California. Cloth. Pp. 281. Price, $2.50. New York: Alfred A. Knopf, 1939.

Syphilis. Presented by the Section on the Medical Sciences. Edited by Forest Ray Moulton. Published for the American Association for the Advance of Science. Cloth. Pp. 193. Lancaster, Pennsylvania: The Science Press, 1938.

Drug Addicts Are Human Beings. The Story of Our Billion-Dollar Drug Racket. How we created it and how we can wipe it out. By Henry Smith Williams, M. D., B. Sc., LL. D., with a Statement of the Narcotics Problem by Hon. John M. Coffee of Washington. Cloth. Pp. 273. Price, $2.50. Washington, D. C.: Shaw Publishing Company, 1938.

Control of Conception. By Robert Latou Dickinson, M. D., F. A. C. S., former Clinical Professor of Obstetrics and Gynecology, Long Island College Hospital; former President, American Gynecological Society, American Gynecological Club, New York Obstetrical Society, Brooklyn Gynecological Society and Brooklyn Hospital staff; Vice-President, Clinical Congress of Surgeons; Lieutenant-Colonel, Medical Advisor to General Staff, Washington, 1918–1919; Senior Consultant, Birth Control Clinical Research Bureau; and Secretary, Committee on Maternal Health, 1923 to date. A Clinical Medical Manual with Numerous Original Illustrations by the Author. Second Edition. Cloth. Pp. 390. Price, $3.50. Baltimore: The Williams & Wilkins Company, 1938.

Scarlet Fever. By George F. Dick, M. D., D. Sc., Professor of Medicine, University of Chicago; Attending Physician, Billings Memorial Hospital; Editor, Department of Infectious Diseases, the Year Book of General Medicine, and Gladys Henry Dick, M. D., D.Sc. Cloth. Pp. 149. Price, $2. Chicago: The Year Book Publishers, Inc., 1938.

Proceedings of the Thirty-Second Annual Convention of the Association of Life Insurance Presidents. Held in the Waldorf-Astoria, New York, December 1 and 2, 1938. Paper. Pp. 239.

Riboflavin (Vitamin B Group).—Recent experiments undertaken by the National Institute of Health of the United States Public Health Service indicate a suspected but hitherto unproved importance of riboflavin (one of the vitamin B group) in human diet.

Riboflavin is one of the vitamins which can be dissolved in water and is not destroyed by ordinary heating or cooking processes. It is considered one of the more important members of the vitamin B group although in the early days it was classified separately as vitamin G.

The vitamin riboflavin is widely distributed in nature in such foods as milk and other dairy products, meat, eggs, and green leafy vegetables. Liver and dried brewers' yeast are especially good sources of this important vitamin.

Riboflavin has an unusual history in that it was discovered quite accidentally and not during the course of feeding experiments. The first recognition of this vitamin came from chemical studies on tissue extracts and on enzymes. It was probably first recognized in 1879 as lactrochrome, or the water-soluble pigment in milk. The isolation, proof of structure, and synthesis, however, have all been done in the last eight years. The vitamin riboflavin has a structure which is probably rather difficult for the body to construct. It must, therefore, be present in our diet.

The daily human requirement of riboflavin may be estimated at one to two milligrams. It is not difficult to meet this requirement through the use of ordinary diets. Forty to eighty grams of fresh liver will supply the requirement as will one quart of milk. Vegetables also are high in riboflavin vitamin content.

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A few suites still available at moderate rentals

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Consultation Room

By FREDERIC LOOMIS, M.D.

One of the most fascinating medical autobiographies ever written, for this is the story of a woman's doctor—a doctor whose world, as he says, has revolved around sex as a pivot, with love as the motive power, and with both happiness and fear as constant attendants.

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PRODUCERS OF
FINE DIGITALIS PRODUCTS

One of a series of advertisements prepared and published by PARKE, DAVIS & Co. in behalf of the medical profession. This "See Your Doctor" campaign is running in the *Saturday Evening Post* and other leading magazines.

STORM WARNING FOR FEBRUARY: RISING MERCURY

THE YOUNGSTER in the picture isn't terribly sick.

He has come home from school with signs of nothing more than an ordinary cold. But his mother, sensible woman that she is, packs him off to bed at once.

For she knows that, at this time of year particularly, *any* cold may be the threshold of pneumonia. She knows that February shares with March the dubious honor of being a "pneumonia month;" that, together, they constitute the season of the year when pneumonia is most prevalent and most dangerous.

Throughout the next six or eight weeks especially, it will be wise to take every possible precaution against pneumonia. Get plenty of rest—for pneumonia's greatest ally is fatigue. Avoid any over-exposure, particularly to extreme cold and dampness.

But above all, if anyone in your family has a cold and his or her temperature rises above normal, don't delay! Call your physician at once. Watch out, too, for chills, pain in the side or chest, and a cough. They, also, are danger signals that should be heeded promptly.

If your doctor is called at once, there is less to fear from pneumonia than ever before. Medical science can offer pneumonia patients more help—can bring about more and quicker recoveries—than in any previous "pneumonia season."

But the pneumonia germ works fast, and every hour counts. If your doctor's treatment is to be most effective, he *must* be called early.

●

PARKE, DAVIS & COMPANY
Detroit, Michigan

The World's Largest Makers of Pharmaceutical and Biological Products

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OPERATIVE SURGERY

A Continuous Course » Will Start April 6, 1939

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METHOD OF INSTRUCTION—Every part of the course will be preceded by a thorough foundation of the anatomy. This will consist of lectures, demonstrations and dissections. The principal operations will then be described by the instructors and performed by the students on fresh human material. Opportunity will be given to have demonstrations on the living.

MINOR SURGERY—Opportunity will be given to perform minor operations such as injections of varicose veins and hernia, blood transfusions, spinal and local anesthesia, injection of hemorrhoids, fissures and fistulas, repair and amputation of cervix, perineorrhaphy, hydrocele, varicocele, minor operations on nose, removal of tonsils (local and general).

CLINICAL WORK—Pelvic and rectal examinations, study of the optic disc and ear drum, paracentesis, cystoscopy.

HOURS, ETC.—The work will be done on Thursdays from 11 a.m. to 2 p.m.

The fee will be $15 per month

Applicants must be graduates of schools approved by the State Board of Medical Examiners

For descriptive circular and further information inquire of

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A. J. REMMEL, M. D., *Director of Operative Surgery* • 1535 JACKSON STREET, SAN FRANCISCO

TWENTY-FIVE YEARS AGO

(Continued from Text Page 168)

ago the secretary very thoughtfully printed in this announcement a list of laboratories and biological depots advertising in the State Journal. Will not every county society that issues a bulletin or prints an announcement, from time to time give a list of a number of different advertisers in some line of activity or another which advertise in the Journal? Will the editors of those bulletins be good enough to call attention to the fact that members may very often save money by buying what they need from our advertisers rather than by sending to some eastern house for the article? . . .

* * *

Where Does the Doctor Come In?—"To the Editor of the State Journal: Dear Sir:—At a meeting of the San Francisco County Medical Society, held January 6, 1914, the plans of the Industrial Accident Board of the State of California, were unfolded to the medical profession. . . .

"The only hope for the medical man who is not in the employ either of the state or an insurance company is lost. He is facing the problem his confrères have faced in Europe and his time for action is now. But if he applies to his county society, the one organized body to which he can appeal, what is the answer? Contract practice is not ethical.

"The time has come and the need is urgent that every medical man must join his county society and see that immediate action is taken for the protection of himself and those dependent on him."

* * *

The California Industrial Compensation Act.—The state law which went into effect January 1 [1914], and which provides for the care, treatment, and compensation of an injured employee, touches our profession immediately and in many essential ways, for, obviously, an injured person must be treated by a physician as soon as possible and thereafter attended by a doctor until he is well. Two quite interesting meetings were held—one in December in Oakland, the meeting of the Alameda County Medical Association, and the other in January at the San Francisco County Medical Society; the former was addressed by Mr. Pillsbury of the Commission, and the latter by Mr. French of the Commission, and by Dr. Morton Gibbons, who has been appointed the medical officer at the head of the insurance feature of the Act. A number of points of great interest were brought out at these meetings. . . .

* * *

Industrial Accident Law.—The New Law. The Boynton Workmen's Compensation, Insurance and Safety Act, Chapter 176 of the Laws of 1913, superseded the Roseberry law on January 1, 1914.

Compensation. The new way of computing compensation, which will be compulsory, excepting for agricultural pursuits and household domestic service, is based on the nature of the physical injury or disfigurement, the occupation of the employee and his age at the time of injury. This will give some men more money than other men, according to the schedule based on the three essentials referred to. In addition, there is provision for pensions, at a reduced rate, for those who are permanently and seriously hurt and who are unable to follow their vocations. In order to meet this extra cost, which affects very few men, the compensation payments will not begin until two weeks after disability. The Roseberry law provided for a waiting period of one week. It is believed the addition of the extra week will pay fully for the pensions of those who have been eliminated from the industrial field. . . .

From an Original Article on "A Plea for the Immediate Operation of Fractures," by Charles G. Levison, M.D., San Francisco.—That the open treatment of fractures is now an accepted procedure is no longer disputed, and it is being rapidly adopted by those surgeons who were formerly most violent in their opposition. One point of the contro-

(Continued on Next Page)

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TWENTY-FIVE YEARS AGO

(Continued from Preceding Page)

versy as to whether fractures should be operated immediately or whether operation should be delayed, is still unsettled, and is the *raison d'être* of this paper.

Before entering upon the discussion of the operation, it must be emphasized that immediate operation should under no circumstances ever be attempted by anyone whose technique is not absolutely perfect, for the remarks that follow here are only intended for those operators whose surgical technique is above reproach. . . .

From an Original Article on "A New Treatment of Poliomyelitis," by D. H. Moulton, M. D., Chico.—We all know from our observation and from our readings what terrible afflictions the recent epidemic of poliomyelitis have wrought upon the babies and children, and even adults, of this and other countries. We see the effect of this dread disease all about us and, aside from plaster paris, braces, and operative procedure, we have been almost powerless to help the little ones and restore them to normal, so that they might take their respective places in the great caravan of life and be normal, useful men and women. . . .

From an Original Article on "Presentation of Patients." Congenital Dislocation of the Hip and Extensive Skeletal Tuberculosis. Radiogram. By Harry M. Sherman, M. D., San Francisco.—A. C., ætat. 3 years in 1897. Sent to me at that date by the late Dr. Henry Gibbons, Jr. The boy had a congenital dislocation of the right hip, with anterior location of the femoral head. A manipulative reduction was easily done, and proved to be stable. Eight months afterward, when the boy was up and about, I found a kyphos, evidence of a vertebral tuberculosis. He was put on a Bradford frame for a year, and then was gotten up in a jacket. Four months later he evidenced a tuberculosis of the left hip and went back on the frame, with traction on the hip added. . . .

From an Original Article on "The Epidemiology and Control of Rabies," by W. A. Sawyer, M. D., Director of the Hygienic Laboratory of the California State Board of Health.—Rabies is a serious and expensive disease which can easily be prevented by the communities involved. A knowledge of its epidemiology is the only reasonable basis for determining the necessary preventive measures. . . .

These three characteristics of rabies—the long incubation period, the short period of infectivity terminated by death, and the transmission by bites only—permit a rough prediction of the course of an epidemic and the formation of a reasonable plan for the control of the outbreak. A more accurate prediction, however, can be based on the study of previous epidemics as a whole. . . .

A few cases of the disease were reported in Southern California before the earliest dates shown by the laboratory records. The curve representing Southern California begins in September, 1909, and shows a sharp rise in November, representing chiefly cases in Pasadena. The next two peaks in the curve coincide with the prevalence of the disease in Los Angeles in 1910. The peak in January, 1911, was caused principally by cases in Riverside. Since then the disease in Southern California has apparently become endemic, with a decreased number of cases in animals and man. The moderate increase in February and March of 1912 occurred in Los Angeles.

The second curve represents the San Joaquin and Sacramento valleys. The first case shown occurred in December of 1909 in Stockton and represents a circumscribed outbreak which showed little tendency to spread. In January, 1911, cases were discovered in the southern end of the San Joaquin Valley. Apparently, the sparsely settled mountainous region between the San Joaquin Valley and Southern California had greatly retarded the extension of the disease northward in spite of the railroad traffic through this region. The disease spread rapidly through the thickly populated farming country on the east side of the valley. The summit of the curve in January, 1912, represents the height of the disease in Fresno, Kings, and Tulare counties.

(Continued on Page 18)

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TWENTY-FIVE YEARS AGO

(Continued from Page 16)

The increase in cases from August, 1912, to March, 1913, was in part due to cases in recently involved communities in the northern end of the San Joaquin Valley, but largely to the passage of the epidemic northward into the Sacramento Valley, involving many towns and the city of Sacramento. Now that the disease had invaded the most populous portions of both valleys, it began to decrease. This curve, representing many communities, is much more gradual in its changes than the curves representing single cities.

In October, 1911, the first case was discovered in San Francisco. In February of the following year the epidemic developed suddenly, and in April it reached its maximum. This is an excellent example of the rapid spread of a disease in a region previously uninvolved. The fall was almost equally rapid and was, undoubtedly, greatly influenced by the measures instituted by the city against the disease. A recrudescence occurred a year later. Since then the number of cases has been small compared with those in neighboring communities.

San Francisco is surrounded by cities and towns, and there is a great deal of travel between them. On all sides but one the traveling is done by ferry, and the egress of dogs in these directions is, therefore, less than if there were no water barrier. The fourth curve shows how the disease spread up the peninsula over the land boundary from San Francisco into San Mateo and Santa Clara counties: There was nothing to prevent dogs from traveling in this direction in considerable numbers, causing repeated invasions of the disease and a correspondingly early and sudden epidemic. The peak of the curve was reached in May, 1912, and was due to the involvement of South San Francisco, San Mateo, Palo Alto and the intervening country. The subsequent rises in the curve represent increases of the disease in the same region. . . .

From the Los Angeles County Medical Association, Annual Report for the Fiscal Year Ending December 18, 1913.—To the Members of the Los Angeles County Medical Association:

Your Secretary-Treasurer begs leave to submit the following report for the forty-third year of the Association, ending December 18, 1913:

Part I. Report of the Treasurer.—Financial report.

The financial report of the Association for the period, December 19, 1912 to December 18, 1913 (with the cancelled check stubs, receipted bills and ledgers, for the inspection of the Auditing Committee), is as follows:

A. Maintenance Income of 1913

Total first half-year dues	$3,672.00
Total second half-year dues	3,636.00
Special assessments	1,779.00
Miscellaneous	11.00
Total all income, 1913	$9,098.00
Carried over from 1912	156.61
Grand total all income during 1913	$9,254.61

B. Maintenance Expenses of 1913

1. Paid assessments to State Society	$2,508.00
2. Envelopes and postage	331.16

(Continued on Page 20)

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1. Boober, Jrl. Amer. Med. Assoc., Volume 110, P. 1920, 1938.

2. Holmes and Deuel: Am. Jrl. Physiol., Volume 54, Page 479. (Recently confirmed in experiments with New Nucoa by university workers.)

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TWENTY-FIVE YEARS AGO

(Continued from Page 18)

3. Printing bills	1,070.90
4. Hall rent	145.00
5. Refreshments at regular meetings	474.26
6. Clerical expenses	766.94
7. Miscellaneous	33.95
8. Telephone exchange	482.19
9. Prosecution of illegal practitioners	1,186.94
10. Special expenses	1,319.94

Summary, 1913

Grand total income	$9,254.61
Grand total expenses	8,319.28
Balance in treasury	$ 935.33

* * *

Part II. Report of the Secretary.—General report of the state of the Association.

The year 1913 may be said to show a continuation of the progress which has marked the career of our society in recent years.

1. *Membership.* The total number of members for whom we paid assessments to the California State Society was 622. The figures show that the Los Angeles Society has doubled its membership in the last eight years. Our society continues in 1913 as the largest county medical unit in the State of California. . . .

10. *Our County Medical Association Telephone Exchange.* Quite the largest proposition that our society inaugurated during the last year is our County Medical Exchange and the work which it hopes to accomplish, and which, we believe, it will most splendidly carry out, have already been explained in some detail in the bulletins of the Society. It is not necessary, therefore, to go over this subject again. . . .

We make our usual apology to any whose feelings we may have hurt. If any such instances have occurred, it was against our wish and desire. Your secretary-treasurer, therefore, thanks you all for your kind coöperation and willingness to aid him in his duties. Respectfully submitted,

(Signed): George H. Kress,
Secretary-Treasurer.

San Francisco County Medical Society: From Presidential Address, by H. B. A. Kugeler, M. D.

Fellow Members of the San Francisco County Medical Society:

I desire to thank the Board of Directors for the honor of electing me their presiding officer and president of the Society.

For eighteen years I have taken an active interest in the affairs of this society, but even that did not bring to my personal knowledge the peculiar complaints of members and nonmembers as to what the Society should do and what it should not do. I desire to emphasize the fact that the most peculiar complaints came from those who were members and who never attended meetings. I have tried in every way possible to impress on the members that the only way that errors in the Society can be corrected is through the active participation of those members in the meetings and proceedings of the Society. To those members of the profession outside of the Society, I have taken every possible occasion to bring home the fact that they could not dream of correcting errors in the Society unless they were members, and by their participation in the discussions and meetings correct any deficiencies that they felt the profession of San Francisco was suffering from. . . .

* * *

Report of Secretary.—As secretary I beg leave to submit the following report for 1913, that is, from December 10, 1912 to December 8, 1913, inclusive.

Membership

The total number of members for whom we have paid assessments to the State Society is 589 as compared with 556 of last year, an increase of thirty-three members for

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the year (thirty-four were really admitted, of whom one came by transfer from Los Angeles, where his assessment was paid). Of this number there are:

Paid up with us		558
Dropped for nonpayment	5	
Died	2	
Transferred	1	
Delinquent	23	31
		589

It may be of interest, as a matter of record, to note the following:

In 1907 the membership was	498
1908	482
1909	482
1910	476
1911	548
1912	556
1913	589

It will thus be seen that, while so-called membership campaigns have not been productive of much good in the past, a steady, persistent effort on the part of this office has led to a gradual increase in our number. There is still considerable work, however, to be done along these lines and, hoping that this may be an incentive to our members to get busy, we wish to state that the membership of the Los Angeles County Society exceeds ours by a considerable number. We should not rest until every eligible physician and surgeon within the county has joined our society. Surely, a little persuasion on the part of a man's confrères should suffice to show him the benefits of membership. . . .

(This is the first time that the San Francisco County Medical Society's books have been so kept as to show the actual financial status were the Society to go out of business December 31. The showing, when one considers the large sums expended for library and the sums expended by the Building Committee and the Committee on Legislation,

(Continued on Next Page)

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TWENTY-FIVE YEARS AGO

(Continued from Preceding Page)

is a most creditable one and cannot be compared with that of last year, when no account was taken of outstanding bills, especially those of the library.) . . .

Respectfully submitted,
(Signed): RENÉ BINE.

From Report of the Milk Commission of the San Francisco County Medical Society.

Mr. President and Members of the Society:

The Milk Commission of the San Francisco County Medical Society has held fourteen meetings this year.

Two new dairies have been certified. . . .

The value of certified milk in infant feeding has again this year been proved on the foundling babies of the city. A death rate of 3.2 per cent is theirs against 9 plus for the city. These babies are uniformly fed on modified certified milk, and are all under two years of age. Two hundred and forty were cared for this past year. The Commission regards itself as peculiarly fortunate in having this practical demonstration of the advantage of clean milk as a basis for infant feeding, for the vital statistics of so large a group cannot be refuted.

In closing, your Commission wishes to urge your coöperation in its efforts to promote the understanding and appreciation of its work for public health in securing and upholding certified milk for our San Francisco market.

Respectfully submitted,
ADELAIDE BROWN, *President.*

From Alameda County Society Report.—The annual meeting of the Alameda County Medical Association was held at the Hotel Oakland on Tuesday evening, December 16, 1913. The meeting was called to order by the president, Dr. M. L. Emerson, at 8:30.

The minutes of the previous meeting were read and approved.

The members then listened to a very interesting address by Mr. A. J. Pillsbury of the California State Industrial Accident Board on the subject of the "Employees' Compensation, Insurance and Safety Act." Dr. Philip Mills Jones, Secretary of the State Medical Society, was present and also made a few remarks on the subject, calling particular attention to the efforts of insurance companies to make a schedule of fees for physicians called to attend cases under this Act which will be altogether too low.

Dr. Dudley Smith made a motion, seconded by Doctor Reinle, that the president appoint a committee of three to confer with the State Industrial Accident Board in regard to the schedule of fees to be paid physicians attending cases under this Act and to report to this Association before any definite action is taken in the matter. Carried. The president stated that he would leave the appointment of this

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committee to the new president. The new president, Dr. Dudley Smith, later made the following appointments on this committee: Dr. G. G. Reinle (chairman), Dr. L. P. Adams, and Dr. Alvin Powell. . . .

BOARD OF MEDICAL EXAMINERS

(Continued from Text Page 168)

initiative measure. The plan, which would put the state's hospitals and medical men under control of a commission of nine members, was presented by Avery C. Moore of Berkeley, formerly associated with the Townsend pension plan.

Highlights of the proposed constitutional amendment:

Facilities of all hospitals now supported in whole or in part by the state would be made available immediately without cost.

Private hospitals would provide the same facilities, but would be compensated for their use.

All physicians, surgeons, osteopaths, chiropractors, and registered nurses would be under the regulation of the commission.

They would be under two classifications—full-time employees of the state with salaries ranging from $2,5000 to $7,500 a year, and those not employed by the state but who would be required to take any case assigned them by the commission, at a set fee.

The proposal did not provide for funds, but specified that they should be included by the Governor in the budget after a year's trial had determined how much money would be needed to carry it out. . . . Mr. Webb will be asked to prepare a title for the measure, which will appear on the state ballot if sufficient signatures are obtained." (San Francisco *News*, December 28, 1938.)

"Arrested by officers today, Jackson L. Martin of Fresno immediately went before Judge M. K. Gibbs and pleaded guilty to a charge of practicing medicine without a license.

(Continued on Next Page)

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BOARD OF MEDICAL EXAMINERS

(Continued from Preceding Page)

He was released under $250 bail until next Tuesday, when he is to appear for sentence. T. P. Hunter, agent for the Board of Medical Examiners, said Martin admitted his license to practice medicine had been revoked in 1928 for performing an illegal operation. Hunter said he went to Martin's office this morning and discussed plans for an illegal operation with the former physician." (San Francisco *Chronicle*, January 1, 1939.) On January 3, 1939, the sentence of 180 days' probation, conditions of which were that he pay a fine of $100 and abstain from further violations of the law, was imposed by Judge Gibbs.

"On the recommendation of the state medical board, two charges of violation of the business and professions code and one of violation of the chiropractor's code were dismissed today against 'Dr.' St. Louis Estes, Los Angeles raw-food advocate. . . ." (United Press Dispatch, dated Oakland, December 28, 1938, and printed in the San Bernardino *Sun*, December 29, 1938.) (Previous entries, November, 1930; January, 1936; December, 1938.)

"Through an inadvertent error, the *Tribune* mistakenly said Thursday that prosecution of St. Louis Estes, health food advocate, was dropped because he agreed to leave California. There was no such agreement; in fact, Estes plans to remain in the Bay region, his attorney, Alexander Mooslin, said yesterday. Mooslin explained that the prosecution of Estes, under the Business and Professional Code of the State (and) Chiropractic Act, was dropped in San Francisco and later in Oakland, because Mooslin informed authorities that Estes would cease using the prefix 'Dr.' with his name. The attorney said that Estes now will advertise as a 'Ph. D., formerly practicing dental surgery, osteopathy, chiropractic, and naturopathic.' He has practiced these in other states but never in California, the attorney said." (Oakland *Tribune*, January 1, 1939.)

"An echo of a case which attracted wide attention here about a year ago was heard today in Superior Court, as Deputy District Attorney William Mahedy presented an order asking for destruction of medical instruments confiscated from Mrs. Laura Miner prior to her trial on abortion charges. Mrs. Miner figured in a coast-wide abortion ring investigation and aided the prosecution in Los Angeles to convict several persons involved. In her trial here, she was acquitted by a jury in Superior Judge Arthur Mundo's court. Mahedy stated that Mrs. Miner gave the district attorney here an affidavit permitting destruction of the instruments. The prosecutor was to ask Mundo to sign the order and then, if the signature is obtained, to instruct Investigator Tom Frost to proceed with the breaking up of the instruments, said to have cost considerable money." (San Diego *Tribune*, December 29, 1938.) (Prior entries, July, September, October, December, 1936; August and November, 1937.)

"Application of the Los Angeles College of Chiropractic for allocation of sixty beds at the Los Angeles County Hospital for patients desiring chiropractic treatments today was referred by the Board of Supervisors to the hospital Advisory Committee and to the Los Angeles County Medical Advisory Board. The college stated that one hundred or more chiropractors would donate services in giving free treatment." (Press dispatch dated Los Angeles, December 24, and published in the Pasadena *Star-News*, same date.)

"Lester R. Daniels, Sacramento, was reappointed to the State Board of Osteopathic Examiners for the term ending December 21, 1941." (Pasadena *Star-News*, December 23, 1938.)

"A man who said he was Romano Nicholas Trotsky, 41-year-old nephew of Leon Trotsky, exiled Soviet leader, appeared in a Los Angeles federal court today and denied

(Continued on Page 26)

"It has been estimated by Tisdall that more than half the foods in the ordinary American diet have no appreciable content of vitamin B_1."*

*Story of Vitamin B_1, Tisdall, JAMA (1935) 105-1583

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Rates, Information and Booklet on Request

BOARD OF MEDICAL EXAMINERS

(Continued from Page 24)

charges he made false statements in applying for American citizenship." (San Francisco *Call-Bulletin,* December 27, 1938.) (Previous entries, April, 1937; May, 1938; Board's annual report, 1937.)

"For years explorers have trodden British Guiana's dank forests with dread of the hollow pop of a blowgun, the whirr of a tiny arrow, and sudden death. The Macusi Indians of the country have the unpleasant habit of tipping their wasp-like missiles with snakes' needle-like fangs, then making matters worse by dipping the fangs in a potion of squashed ants and deadly curare, juice of a species of plant. Last week the curare part of the potion made news in San Francisco, not by getting under the skin of hardy explorers but because it had been penetrating the epidermis of chronic drunks. The California Board of Medical Examiners hailed a nonmedical man named Thomas F. H. Huston, his assistant, and two nurses into court on charges of practicing medicine without a license. While doctors sometimes use small amounts of curare in tetanus cases, the Board contended that Huston had no right to give it to the drunks taking his 'cure'—it contended he had no right to give them drugs of any type, for that matter. More than three years ago Huston, a former embalmer, had set up operations legally; he was licensed by the state to run a private sanatorium—called the Samaritan Treatment Institution—for alcoholics who needed a rest. But, so the charges declare, he did more than give his cases rest; he offered three Samaritan treatments, consisting of injections of drug mixtures known as No. 1, No. 2, and No. 3 (No. 2 was the curare-containing formula and was reserved for the most incorrigible drunkards). These shots, bringing on nausea, were employed in treatments costing about $150 and lasting two or three days, with the understanding that the patient was to come back for more if he was not cured. Whether it was the South American poison or just the treatment in general, many Samaritan-

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treated alcoholics didn't like it. They started kicking to the State Board of Medical Examiners, and when complaints had accumulated the Board issued formal charges against the Huston group. . . . The case is expected to be tried next month." (*News Week*, December 12, 1938.) (Previous entry, January, 1939.)

"C. C. Chappelle, 66-year-old former San Jose physician whose license was revoked several months ago by the state medical board, was granted straight probation by Superior Judge William F. James today on a charge of performing an illegal operation. Probationary term was set at three years with the condition that Chappelle refrain from engaging in his profession for the rest of his life. . . . 'I am not sentencing you to jail because of your physical condition and also because I feel that you have already suffered as much as a man could suffer by losing your license to practice your profession,' Judge James told Chappelle. . . . (Probation Officer) Watson's report said that the district attorney's office have had numerous complaints of his asserted illegal medical practice here, but that this was the first time a complaint had been formally sworn in court. . . ." (San Jose *News*, December 9, 1938.)

"Preliminary hearing on charges of transportation and possession of narcotics will be held next week for Dr. Lee E. Smith, fifty-eight, of 1445 Sixty-eighth Avenue, and Dorothy Wakefield, alias Grace Moore, forty-two, nurse of 3241 Mountain Boulevard, State Division of Narcotic Enforcement, officers said. The couple were arrested by Agents Fred Stemm and L. E. Rice on November 17 on Mountain Boulevard, in the Wakefield woman's car. She is charged with transportation, he with possession. Morphin valued at $400 was seized, Stemm said. Both pleaded not guilty. Meanwhile, the State Attorney-General's office moved to seize the woman's automobile through civil proceedings." (Oakland *Tribune*, December 11, 1938.) (Previous entries, December, 1932; April, May, December, 1936.)

(Continued on Next Page)

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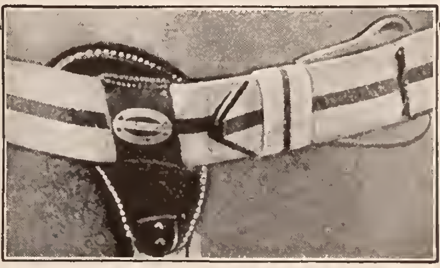

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BOARD OF MEDICAL EXAMINERS

(Continued from Preceding Page)

"Dr. J. H. McMurtry, Clovis physician, was arrested late yesterday by an agent of the State Board of Medical Examiners on a charge of practicing medicine without a license. He was released on the posting of $500 cash bail. J. W. Williams, representing the State Board, said Doctor McMurtry continued his practice despite the revocation of his license in October, when the Board found him guilty of performing five abortions. Doctor McMurtry said today he had applied for a writ of review in the superior court, and had continued his practice on the advice of his attorney, who informed him the appeal would automatically stay the Board's order revoking his license." (Fresno *Bee and Republican,* December 9, 1938.) (Previous entry, December, 1938.)

"Where professional services are donated by a physician to county hospital in care of a patient later discovered to be a nonindigent, the physician should be entitled to require the patient to pay, according to an opinion given out today by the District Attorney. The District Attorney's inquiry indicated it has been the custom for physicians to request payment of such patients, but the county has taken no part except to collect for itself, the opinion stated. The study was made when Los Angeles County Hospital authorities inquired concerning the San Diego County method of handling such problems." (San Diego *Tribune,* November 30, 1938.)

"Charging a conspiracy to injure him in his profession as a metaphysician and doctor of psychology, Adolph Oosterveen filed suit in the Superior Court today against Ecquiel C. Montijo, Manuela Lopez and others for $52,000 damages. The defendants falsely accused Oosterveen of practicing medicine without a license and caused his arrest on that charge, but he was tried and acquitted in court, according to the complaint." (Los Angeles *Herald and Express,* December 7, 1938.)

"The last decision to be handed down by the late Superior Judge J. J. Trabucco, who died this morning, was the denial of a new trial to a physician and a former policeman, who had sued a widow for $9,875. The decision, mailed on Saturday from Dante Hospital, where he was ill, was received by the clerk of Superior Judge George J. Steiger's court this afternoon. The suit, filed by Dr. Nathan S. Housman and John C. Farrell against the widow of Lewis M. Baker, involved expenditures alleged to have been incurred during Baker's fatal illness." (San Francisco *Call-Bulletin,* December 13, 1938.) (Previous entries, November, December, 1932; July, 1933; January, 1937.)

"A criminal complaint, accusing Dr. T. Maude Ramer of performing an illegal operation was issued by the district attorney's office today. Doctor Ramer, sister of Dr. Blanche Ramer, found guilty of a similar charge last summer, is alleged to have performed the operation December 10 upon Mrs. Edith Monteith, thirty, of 1470 Second Avenue. Mrs. Monteith was in Mercy Hospital today in a serious condition as the result of the operation, the state contends. Investigators sought Doctor Ramer with a warrant." (San Diego *Sun,* December 17, 1938.)

"The Pacific Health Corporation, a San Francisco group health association, yesterday appealed to the United States Supreme Court from a State Supreme Court decision that it practiced without a license. By selecting physicians to administer to its members the health organization actually was practicing medicine in violation of the state's Medical Practice Act, the State Court held. In asking the high tribunal to void the decision, the corporation, according to Associated Press dispatches from Washington, D. C., did not question the validity of the California law in so far as it prohibited any unqualified or unlicensed physician from practicing medicine. The appeal was the second development in two days in the fight over group health. Tuesday the Department of Justice obtained indictments against the American Medical Association, three affiliated societies, and

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twenty-one physicians on a charge of violating the anti-trust laws." (San Francisco *Chronicle*, December 22, 1938.)

"Dr. John A. Kelleher, 333 Monterey Boulevard, was arrested by State Narcotic Bureau agents last night on three charges of furnishing narcotics. The agents, accompanied by Police Officer Edward Oliva, took Kelleher into custody at his 10 Twenty-ninth Street offices." (San Francisco *Chronicle*, December 20, 1938.)

"A thief in search of narcotics was believed to have stolen an automobile belonging to Dr. C. B. Alexander, Alhambra physician, from a parking lot late Wednesday. The car was recovered by Radio Officers Buhman and Dixon in an alley south of Main near Almansor Street a few hours later. A medicine bag had been removed from the car." (Alhambra *Post-Advocate*, December 22, 1938.)

"Deputies of the sheriff's station at San Dimas today sought to locate the physician whose professional bag was found last night on Cienga Avenue in the Charter Oak district. The bag, empty, apparently had been thrown from an automobile, deputies said. It was a black, Boston-style bag, bearing the initials 'Dr. C. B. A.,' stamped on the side. The bag will be held at San Dimas station for a few days for possible identification, and then if unclaimed will be turned over to the sheriff's property department in Los Angeles." (Pomona *Progress-Bulletin*, December 22, 1938.)

"Comedian W. C. Fields, charged $12,000 for a month's medical treatment, doesn't have to pay because the amount 'shocks the conscience,' the State Appellate Court had ruled today in San Bernardino. The court reversed a $12,000 judgment granted by Superior Judge O. K. Morton of Riverside to Dr. Jesse Citron, who treated Fields when he was ill with pneumonia in 1936. Judge Morton erred, the Appellate Court said, when he refused to hear cross-examination as to the Hemet, California, physician's earnings and his usual charges in such cases. . . .· Doctor Citron had testified at the trial that Fields' illness was complicated by his habit of drinking 'from a quart to two quarts of whiskey daily,' and that his treatment sharply reduced the patient's appetite for liquor." (Los Angeles *Herald and Express*, December 21, 1938.)

"The Department of Professional and Vocational Standards as it is now set up in the state government appears to be one of the chief worries of the Democratic Administration, which will assume control in January. . . . Of particular interest to the Administration is the huge reserve fund which has been built up through the years from fees charged for licenses and examinations. That money has an untouchable status now, because it is collected for the sole purpose of maintaining the department and the particular bureau which collects it, and the surplus cannot be turned back into the general fund to be used for general governmental purposes. . . . A quiet investigation has already been started by H. Dewey Anderson, relief director, . . . to see if something cannot be done to consolidate many of the bureaus in the department. . . . Anderson would like to work out some amendment to the law which would permit the excess funds to be turned over to the general fund at the end of the year in order to meet the mounting cost of relief. Such a move would immediately arouse the antagonism of the professional and vocational groups affected, and it is doubtful that such legislation could be forced through either house of the legislature. . . ." (Oakland *Tribune*, December 22, 1938.)

"Two 'treasure hunt' asserted dope peddlers, who buried narcotics under bushes in Golden Gate Park, were arrested by federal narcotics agents here today. At the same time the agents nabbed a local chiropodist and booked him on charges of possessing more than two hundred tablets of morphin. The arrested men gave their names as Hugh Johnson and William Murphy and Dr. William A. Roberts.

(Continued on Page 31)

Bequest Forms: Unto the California Medical Association*

FORM OF CLAUSE OF WILL PROVIDING FOR CASH BEQUEST

I hereby give and bequeath unto Trustees Of The California Medical Association, a nonprofit corporation of California, the sum of $——— to be known as the ——— Gift, to be used and expended by said corporation for scientific, educational, or hospital purposes.

* * *

FORM OF CLAUSE OF WILL PROVIDING FOR CASH BEQUEST

I give and bequeath unto Trustees Of The California Medical Association, a nonprofit corporation of California, the sum of $———, to be held as a fund, to be known as the [here insert name desired] Fund, the principal whereof shall from time to time be invested to the best advantage compatible with safety, and the income whereof shall be used and applied for scientific, educational, or hospital purposes.

* * *

FORM OF CLAUSE OF WILL PROVIDING FOR BEQUEST OF PERSONAL PROPERTY

I give and bequeath unto Trustees Of The California Medical Association, a nonprofit corporation of California [here describe the property], the same, or the proceeds thereof, to be held as a perpetual fund, to be known as the [here insert name desired] Fund, the income whereof shall be used and applied for scientific, educational, or hospital purposes. The said corporation shall have the power to sell said property and to invest and reinvest the proceeds arising from the sale thereof from time to time as it may deem advisable for the purpose of producing as large an income as may be compatible with safety.

* * *

FORM OF CLAUSE OF WILL PROVIDING FOR DEVISE OF REAL PROPERTY

I give and devise unto Trustees Of The California Medical Association, a nonprofit corporation of California, to aid and further its scientific, educational, and hospital purposes, and to be known as the ——— Gift, the following described real property situate in the County of ———, State of California, and more particularly described as follows, to wit:

* * *

FORM OF CLAUSE OF WILL PROVIDING FOR DEVISE OF REAL PROPERTY

I give and devise unto Trustees Of The California Medical Association, a nonprofit corporation of California [here describe the property], the same, or the proceeds thereof, to be held as a perpetual fund, to be known as the [here insert name desired] Fund, the income whereof shall be used for and applied to the support and maintenance of scientific, educational, or hospital purposes. The said corporation shall have the power to sell said property and to invest and reinvest the proceeds arising from the sale thereof from time to time as it may deem advisable for the purpose of producing as large an income as may be compatible with safety.

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* These Bequest Forms were discussed editorially in California and Western Medicine, for March, 1936, p. 145, and June, 1936, p. 460.

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BOARD OF MEDICAL EXAMINERS

(Continued from Page 29)

Johnson and Murphy resorted to a new trick, according to Major Joseph A. Manning, in charge of the federal agents, by hiding out morphin cubes in 'caches' in the park. When they made a sale, Major Manning said, they drove their customer to the park in an automobile, removing enough morphine from their open-air 'safes' to meet the customer's need. They were charged with possession, sale and transportation of morphin, and their automobile and a quantity of narcotics confiscated. In the other case, Doctor Roberts, who cannot have narcotics lawfully in his possession, according to Major Manning, was found with a large quantity of morphin in his office. He was charged merely with possession." (San Francisco *Call-Bulletin*, January 9, 1939.)

"Mrs. Zahda I. Duysen, 915 West Fourth Street, was found guilty on charges of violation of the State Medical Practice Act after a court trial yesterday by Municipal Judge Wilber F. Downs. . . . Several men and women testified that they bought courses of treatment from the defendant. The treatments, according to the testimony, consisted of several different kinds of medicine, including mineral liquids, snake oil, capsules, and tablets. . . . Attorney O. R. Young, counsel for Mrs. Duysen, contended that his client was not guilty of violating the medical practice law, as she was merely a peddler with a license from the State Board of Pharmacy as an itinerant drug peddler." (Long Beach *Sun*, January 6, 1939.)

If men gave three times as much attention as they now do to ventilation, ablution, and exercise in the open air, and only one-third as much to eating, luxury, and late hours, the number of doctors, dentists and apothecaries, and the amount of neuralgia, dyspepsia, gout, fever, and consumption, would be changed in a corresponding ratio.—J. F. Clerk.

Immediate Action Under New Food and Drug Act.—Action to enforce several sections of the new Food, Drug and Cosmetic Act were begun instantly, says the annual report of the Food and Drug Administration, although the new bill became law only five days before the close of the fiscal year which this report covers. The first enforcement of the new legislation dealt with dangerous cosmetics, in particular with poisonous eyelash dyes, reports W. G. Campbell, Chief.

Other provisions which went into effect immediately when President Roosevelt signed the act on June 25, 1938, dealt with dangerous drugs and with new and untried drugs. These two sections were an outgrowth of two of the more spectacular services by the Administration within the year covered by this report. These were the "Elixir of Sulfanilamide" catastrophe and the "cancer serum" episode.

A special report required by Congress covered the main points in the sulfanilamide tragedy, and the present report is limited to facts not available when the Secretary's report was submitted. The Administration emphasizes that the disastrous results came from the use of an untested and highly poisonous solvent, diethylene glycol, and not from the drug, sulfanilamide itself, which is recognized as a valuable curative agent when administered under competent medical advice. Diethylene glycol and several other glycol solvents have been used in certain flavoring extracts, against the advice of the Administration. The "elixir" disaster demonstrated clearly the dangerous possibilities of these solvents. In consequence inspectors seized many lots of extracts and flavors as well as of the solvents, and the distributors promptly recalled outstanding stocks so that the market was soon cleared of this menace.

As an indication of the thorough manner in which the Food and Drug Administration mobilized in the "Elixir" campaign, Mr. Campbell reports that a final check up accounted for 99.2 per cent of all the elixir that has been prepared. The "cancer serum" search was complicated by a mistake by the attending physician in reporting the source of the serum which was contaminated by tetanus toxin. Chiefly as the result of the "cancer serum" and "elixir"

(Continued on Page 34)

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OFFICIAL JOURNAL OF THE CALIFORNIA MEDICAL ASSOCIATION

VOL. 50 FEBRUARY, 1939 NO. 2

California and Western Medicine
Owned and Published by the
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Change of Address.—Request for change of address should give both the old and the new address. No change in any address on the mailing list will be made until such change is requested by county secretaries or by the member concerned.

Responsibility for Statements and Conclusions in Original Articles.—Authors are responsible for all statements, conclusions and methods of presenting their subjects. These may or may not be in harmony with the views of the editorial staff. It is aimed to permit authors to have as wide latitude as the general policy of the Journal and the demands on its space may permit. The right to reduce or reject any article is always reserved.

Contributions—Exclusive Publication.—Articles are accepted for publication on condition that they are contributed solely to this Journal. New copy must be sent to the editorial office not later than the fifteenth day of the month preceding the date of publication.

Contributions—Length of Articles: Extra Costs.—Original articles should not exceed three and one-half pages in length. Authors who wish articles of greater length printed must pay extra costs involved. Illustrations in excess of amount allowed by the Council are also extra.

Leaflet Regarding Rules of Publication.—CALIFORNIA AND WESTERN MEDICINE has prepared a leaflet explaining its rules regarding publication. This leaflet gives suggestions on the preparation of manuscripts and of illustrations. It is suggested that contributors to this Journal write to its office requesting a copy of this leaflet.

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EDITORIALS[†]

CALIFORNIA PHYSICIANS' SERVICE: A STATE-WIDE MEDICAL SERVICE BY THE CALIFORNIA MEDICAL PROFESSION

Action Taken by the California Medical Association House of Delegates.—Since December 17–18, 1938, when the House of Delegates of the California Medical Association met, responding to a call by the California Medical Association Council at its meeting of November 12, the citizenry of California and, in fact, of the United States, have been aware, through the press association dispatches, that a new form of medical service, on a state-wide plan, was about to be tried out in California. The text of the call for the special session of the Association's supreme legislative body—the House of Delegates—and the reasons for convening the delegates were given in the editorial and other departments of the December and January issues of CALIFORNIA AND WESTERN MEDICINE. The following comments, therefore, will deal more with subsequent events, such as the enabling resolutions of the Council, subsequently acted upon by the House of Delegates, which may be found on page 40 of the January issue of the OFFICIAL JOURNAL.

* * *

Steps in Further Organization.—In accordance with the instructions given by the House of Delegates on December 18, the Council, on Saturday, January 14, 1939, took steps to bring about the incorporation of the new organization—a nonprofit corporation, separate and distinct from the California Medical Association—and to indicate who among the members of the California Medical Association were to have the responsibility of serving as the first "administrative members" and the first "board of trustees."

The new organization, itself a corporation, naturally must have a governing body or board of directors; and this group is named the Board of Trustees. The trustees, in turn, must be elected by persons who possess voting qualifications as outlined in the Association's by-laws. These voters, who may or may not be doctors of medicine, are called administrative members, and the number of such is not to exceed seventy-five. Some of the initial administrative members will give up their positions later to physicians who will be elected as regional representatives (two from a district) in a set-up that contemplates about fifteen such districts, into which California will be divided.

[†] Editorials on subjects of scientific and clinical interest, contributed by members of the California Medical Association, are printed in the Editorial Comment column which follows.

* * *

Incorporation Plans.—When the House of Delegates met in Los Angeles on December 17, its members were given copies of the tentative drafts of the medical and hospitalization service plan as prepared by the Special Committee, and approved by the Council. The House, in turn, through its own Reference Committees, again as Committee of the Whole, and acting also as the House, considered and passed upon the plans proposed and submitted, and also gave instructions to the Council to proceed with the organization of the new nonprofit corporation. Some delay, as might be expected, is always encountered when an application for incorporation, needing signatures of incorporators residing in different parts of the State, is prepared for submittal to the State authorities. However, once the incorporation is completed, its Board of Trustees can begin to function officially, and further development of the plan should then proceed in an active manner. It is not possible to state definitely the period of time necessary to accomplish these ends, especially for an enterprise of such wide scope, for which, while it is important that no time be wasted, it is likewise equally desirable that no undue haste, likely to contribute to error, be evidenced.

* * *

Members of the First Board of Trustees.—The group of seven physicians who have been named for places on the first board of trustees of this California Physicians' Service include the following: Drs. Ray Lyman Wilbur, Stanford University; Lowell S. Goin, Los Angeles; T. Henshaw Kelly, San Francisco; C. Kelly Canelo, San Jose; W. Earl Mitchell, Berkeley; Samuel Ayres, Los Angeles; Alson R. Kilgore, San Francisco.

For additional information concerning these and other organization steps, readers are referred to the California Medical Association department in this issue, on page 132.

* * *

Some Basic Purposes.—It is well for all California physicians to keep in mind that the proposed medical-service plan is designed to operate on a nonprofit basis, and that it is to be a voluntary organization, both as regards the doctors of medicine, namely, the "professional members," who register to give service, and as pertains to citizens of certain income brackets who, through periodic payments, choose to avail themselves of the professional services so offered—this latter group to be known as "beneficiary members." The plan, it is equally well to observe, does not contemplate any essential interference with medical practice as it now exists. On the contrary, special efforts are and will continue to be made to maintain the standards of medical practice and of scientific medicine, as they now obtain, and to promote their continued and legitimate development.

Not an Insurance Plan.—The California Physicians' Service is not an insurance or similar health plan. Rather, it is a method which aims to make it possible for citizens of certain income classes, through periodic payments, to secure for themselves the professional services of physicians of their own choosing, exactly as they make such choice today, through payments rendered to the California Physicians' Service instead of to the doctors of medicine who gave the services. The California Physicians' Service, in turn, will then pay the physicians on what is called the unit basis.

The schedule of charges—or so-called fee table—to be used as the basis for payments will probably be one that is in accord with the averages in vogue for services rendered in California, and certainly not lower; and the payments to the physicians who have rendered service in a particular month will be on the "unit basis." Thus, to illustrate, if a certain service is rated as being entitled for remuneration, say, to the amount of five dollars, and the unit selected should be one dollar per unit, then the physician who had rendered and submitted a statement for five dollars would be credited as eligible for repayment on the basis of five units. Whether the unit would measure up to 100 per cent (one hundred cents on the dollar) would depend upon the amount of money remaining in the fund after administrative and hospitalization services had been covered.

* * *

Information Brochure in Preparation.—The foregoing statements are made in the OFFICIAL JOURNAL to acquaint the members of the California Medical Association, in a general way, with some of the basic provisions in the "California Physicians' Service." The Council, however, has instructed its Special Committee to prepare a brochure that will give more explicit information on many details in which all doctors of medicine in California have a very natural interest. The pamphlet so prepared will be placed in the mails as promptly as possible, and a copy will be sent to every Doctor of Medicine licensed in California. In the meantime, it is well to remember that the California Physicians' Service is an organization that has been brought into being through action, carefully considered, by the House of Delegates, the representative body of elected delegates in whom is vested the supreme authority to act for the members of the Association. That action having been taken, the responsibility for carrying the plan through to satisfactory end-results will be vested jointly in the officers of the new corporation and the members of the California Medical Association. With careful thinking and wholehearted coöperation, the plan should soon be put into successful operation.

DEL MONTE ANNUAL SESSION

This Year's Programs Have Exceptional Lure.—In all years, the advice to attend the annual session of the California Medical Association may be properly given; but this year the suggestion comes with special force to members of the

Association. Not only for the valuable scientific and other programs, but because of the widespread interest in the Medical Service plans, soon to be put into operation in California, this coming gathering should have particular appeal. At a recent meeting of the Committee on Scientific Work, the reports of the secretaries of the twelve scientific sections indicated more than ever that the time necessary for attendance may be put to most profitable use.

Several joint sessions will be held with symposia on topics such as sulfanilamid, chronic alcoholism, and poliomyelitis. The guest speakers include: Dr. Chester Keefer, Harvard University; Dr. Stuart Harrington, Mayo Clinics; and Dr. U. V. Portmann, Cleveland Clinics.

The clinical pathological conference, to be conducted by Dr. Chester Keefer, in coöperation with California colleagues, will undoubtedly measure up to the excellent standard of previous years.

The first general meeting on Monday morning, May 1, will be given over to the addresses of President W. W. Roblee of Riverside and other speakers, who will present, among other things, progress reports on the Association's plans for a statewide, voluntary medical service.

The programs of the scientific sections, the scientific exhibits and the technical-commercial booths, as outlined in the tentative plans, should all be of interest and value.

In the scientific exhibit section, it is proposed to present an almost continuous series of films on medical and surgical work.

* * *

Hotel Reservations Should Be Made.—Del Monte and the Monterey Peninsula are outstanding in possessing surroundings of never failing attraction to all who love the great out-of-doors or an environment of historical interest. Members who do not journey to Del Monte by automobile may use with equal convenience railroad transportation. A one and one-third round-trip rate will be secured for those who present travel certificate forms from county society secretaries, and, in due time, these will be forwarded. In the California Medical Association department* in this issue is given a list of the hotels, with rates, location, and other information. All members who contemplate attendance at the annual session, May 1-4, should promptly write for reservations. Why not lay plans now to attend the 1939 annual session?

PRESIDENT-ELECT CHARLES A. DUKES' VISITATIONS TO COUNTY SOCIETIES IN SOUTHERN CALIFORNIA

Visitation Itineraries of President Roblee and President-Elect Dukes.—Commencing on Monday, January 16 and ending on Wednesday, January 25, President-Elect Charles A. Dukes of Oakland, with the Association Secretary and District Councilors C. L. Emmons, Carl A. Howson and Louis A. Packard visited the following societies: Orange, Pasadena, Riverside, Los Angeles, San Diego, Imperial, Ventura, Santa Barbara and San Luis Obispo. At each meeting there was a full attendance. In Los Angeles the large auditorium was filled, with overflow attendance in the dining rooms, where loudspeakers had been installed.

In November last, President W. W. Roblee covered most of the northern and central counties in California. Since, in recent years, it has become evident that the demands upon the time of the presiding officers of the State Association for visitation work are so great, a plan has been devised whereby, annually, the President-Elect will take for visitation the county societies in one portion of the State, and the President, in the succeeding year will visit the county units in the other part of California.

* * *

Medical Service the Major Topic.—In President Roblee's tour in November the subject for discussion was "The Good of the Association," with emphasis on national and state trends in medical service. President-Elect Dukes, however, was called upon to speak on the plans for a special service recently formulated in California, and now being put into operation. At each meeting a full presentation of the plans was made, ending always with the request that questions be asked. The large attendance at the meetings and the numerous queries submitted are indications of the deep interest taken by members in the proposed "California Physicians' Service."

The California Medical Association is greatly indebted, therefore, to President W. W. Roblee and President-Elect Dukes for their more than generous donations of valuable time, and for the efficient services they have rendered to organized medicine in California in cordially meeting the members of the local societies and frankly and ably discussing with them some of the major problems now confronting the medical profession. Truly, officers of medical associations, in our present day, hold positions that no longer belong merely to the honorary class. An official position in a medical society, today, means work, and plenty of it!

POSTGRADUATE CLINICAL CONFERENCES

Clinical Conferences with Teams to Be Held in Northern, Central and Southern California. Component county medical societies will shortly be contacted concerning the holding of clinical conferences within their districts. The State Committee on Postgraduate Activities hopes to secure the coöperation everywhere of county society units for a series of spring and fall clinical conferences, designed respectively to carry the work to Northern, Central and Southern California. In each section it is planned to send out one or two teams, for several days at a time, each team covering a territory conveniently located. For this potential work the aid of faculty and nonfaculty teachers and demonstrators has been promised. Shortly, full information concerning these graduate conferences will be forwarded to each county society, with a request for coöperation from their angles.

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* See page 137.

In several states, postgraduate activities have been put into operation on a statewide basis and with excellent, even astonishing results; and California should not be laggard in this important work. Officers and program committees of local societies are urged to arrange their meeting schedules so that the holding of clinical conferences in their districts may be promoted. Already, during the last several years, the San Joaquin County Medical Society, under the leadership of Dr. C. A. Broaddus, and his coworkers, has demonstrated the value of consistent postgraduate work, and last year the medical societies of Santa Barbara, Kern and Ventura counties held a two-day, Saturday-Sunday graduate session that met with excellent attendance and hearty approval. May not the example set by these societies be well followed by other county units?

PRESIDENT ROOSEVELT'S HEALTH PROGRAM

Presidential Message of January 23, 1939. As this February issue of California and Western Medicine goes to press, dispatches from Washington indicate that Congress will be urged by President Franklin D. Roosevelt to enact part of the health program put forward by the Technical Group appointed by President Roosevelt's Interdepartmental Committee; the report of the two committees having been presented at the National Health Conference which convened in Washington on July 17, 1939.

Recommendations of the Health Conference have already been commented upon in previous issues of the Official Journal. It may be recalled that in a five to ten year health-development program, as outlined by the lay technical experts, it was proposed to spend as much as eight hundred and fifty million dollars during the peak year of the effort! It is reassuring, therefore, to note that the present Congress will be called upon to appropriate no more than fifty million dollars for a beginning of the work, and this along lines of health conservation with which the American Medical Association and its constituent state organizations are in full accord.

As given in the preliminary newspaper reports, the present program should meet with the joint approval of citizens and members of the medical profession. (In this issue, see also pages 139-140.)

* * *

A Provision of Particular Interest.—Worthy of special mention is the inclusion of a provision mentioned in the statement:

"1. Pay physicians to care for those too poor to afford medical care."

This official recognition of the obligations of the public in the care of the indigent sick has been too long delayed, so far as it relates to official governmental announcements, and its promulgation at this time, therefore, is all the more welcome.

The Text of the Washington Announcement. For members of the California Medical Association who may have missed reading the item referred to, the first Associated Press dispatch on the subject is printed below:

> PRESIDENT ROOSEVELT URGES HEALTH PLANS TODAY
>
> *Special Message to Congress May Ask Eight Hundred and Fifty Millions Yearly for Big, Long-Range Program*
>
> Washington, January 22 (AP).—President Roosevelt is expected to urge Congress, in a special message tomorrow, to enact legislation for a huge, long-range health-improvement program.
>
> The health program, which would provide for expenditures of up to eight hundred and fifty million dollars annually from state and federal funds by 1949, has been a controversial issue since it was recommended to Roosevelt last July by his special Interdepartmental Committee on Health and Welfare.
>
> Wagner Has Bill
>
> Senator Wagner (Democrat), New York, has prepared a bill calling for a fifty-million-dollar appropriation to begin the proposed health program.
>
> While the proposal stirred up some opposition in medical circles, the American Medical Association agreed last September with the Interdepartmental Committee that there was a vital need for an extension of existing medical facilities.
>
> Dr. Irvin Abell of Louisville, Kentucky, President of the Association, conferred last week with President Roosevelt and said afterward that the Association was in full agreement with the Chief Executive on the need for the use of Government funds in promoting the health of the nation.
>
> Money Program
>
> *Money appropriated for the health program would, according to recommendations of the committee, be used to:*
>
> *1. Pay physicians to care for those too poor to afford medical care.*
>
> *2. Assist existing hospitals and build new ones where needed, particularly in rural areas.*
>
> *3. Establish clinics for quick diagnosis and treatment of disease.*
>
> *4. Encourage vaccination against preventable diseases.*
>
> *5. Develop maternal and child welfare facilities, including baby clinics, schools for expectant mothers, visiting nurses, and obstetrical care if needed.*
>
> *6. Stimulate public health service to control disease through such activities as controlling stream pollution, establishing more efficient quarantines, health instruction for both children and adults, and closer inspection of milk and water supplies.*
>
> *Funds would be allotted to states and communities under restrictions requiring that they do their part in health promotion.*

SCIENTIFIC MEDICINE AND WARS

Address of Dr. Edward M. Pallette.—At the Del Monte annual session of two years ago, the retiring president, Dr. Edward M. Pallette of Los Angeles, gave to his presidential address the title, "Human Betterment." In his discussion of organic evolution he called attention to the manner in which the advances in scientific medicine had in one sense created an imbalance, through making possible the accretion to our population of many individuals who in former centuries, under the rule of the survival of the fittest, would not have lived to adult life.

Several of Doctor Pallette's statements, to which exceptions were taken, are as follows:

> We are fast approaching a condition when we will be a nation of adolescents, governed by adolescents, for adoles-

cents. Or, if you will, a nation of subnormals, governed by subnormals, for subnormals. . . .

And morons all have large families of physically healthy little morons—always morons. . . .

* * *

Views of Major General William C. Rivers, U. S. A.—Along the line of Doctor Pallette's thought, but from a different angle and on a different subject, we find in an International News dispatch from New York, dated January 22, the following interesting item:

> MEDICINE AID TO WAR TOLD
>
> Medical science is responsible for the great wars of modern times because it provides warring nations with the necessary human "cannon fodder" by curing or preventing diseases which years ago wiped out whole armies.
>
> That charge was made tonight by Major General William C. Rivers, one of the most distinguished officers in the United States Army, now retired. He spoke with several other prominent Army and Navy officers at a forum, entitled "Has Science Made War More Terrible?" presented by the American Institute.
>
> Disease Conquered
>
> "If you had attempted thirty years ago or so to mobilize the fifty million men put into the field by only five nations of Europe for the World War, some twenty million of them would have died of disease in the training areas.
>
> "The remaining thirty million would have gone into the war itself weakened by diseases of the training camps—diseases like typhoid fever, which modern medicine now can control and prevent."

The above are given space because there is much room for thought on the points brought out, especially to doctors of medicine, who have had biologic training.

Other State Association and Component County Society News.—Additional news concerning the activities and work of the California Medical Association and its component county medical societies is printed in this issue, commencing on page 132.

EDITORIAL COMMENT†

MICROBIC METAZOA

A revolutionary change is taking place in bacteriological theory as a result of the rapidly increasing evidence that certain bacterial colonies show specializations within the cell population, and integrations by means of a primordeal nervous or circulatory system. The initial observation suggesting this futuristic theory was the isolation by Muto [1] of a nonpathogenic microörganism from his own saliva that was capable of forming motile colonies on agar plates. Since these colonies crawl about in a manner suggesting the movement of snails or slugs, he named his buccal bacillus "Bacillus helixoides." About a year ago two similar microorganisms were isolated from the intestinal contents of worms by Smith and Clark [2] of the Bureau of Plant Industry, Washington, D. C. The American species were named "Bacillus alve" and "Bacillus circulans."

Cinematographic studies of B. helixoides (or B. alve) colonies are currently reported by Shinn [3] of the Western Pennsylvania Hospital, Pittsburgh, Pennsylvania. Moist agar plates were seeded with this microörganism and placed in a photographic apparatus, fifteen automatic exposures per hour being made over a period of two days. A study of the resultant films showed that there are at least four stages in the development of individual colonies. Maximum colony motility was noted in the initial stage of development, before the colonies had grown to more than 0.5 millimeter in diameter. Under low magnification the small colonies often shot across the field of view with bullet-like precision. The path was rarely linear for a considerable distance, but usually consisted of a series of wide circulating loops. The calculated average speed was about 14 millimeters per hour.

As soon as the growing colonies reached 0.5 millimeter in diameter, an abrupt stop of all forward movement was usually noted, the beginning of the second or dormant stage. Growth continued during this rest period. As soon as the dormant colonies reached about 1.0 millimeter in diameter, motility was resumed. Linear movements were never observed in these awakened colonies, motility taking the form of rapidly accelerating rotations of the cell mass. In 99 per cent of the 250 rotating colonies studied in the Pittsburgh laboratory, the direction of rotation was counterclockwise. The maximum speed of rotation was inversely proportional to the diameter of the colony, and averaged about 1.4 r. p. h. for the 250 colonies studied. "As the rate (of rotation) increases, spiral arms are extended from many colonies, so that they resemble spiral nebulae. Fragments are frequently detached to lead an independent existence, and may depart entirely or continue to circle the parent as a satellite. Some colonies will detach a complete ring of growth which continues to rotate about the center at some distance from it." As the colonies approach two millimeters in diameter, the rate of rotation gradually decreases, the colony eventually "freezing" into terminal senility.

Assuming that linear and rotary motions of these colonies are due to cilia, Doctor Shinn concludes that "it would be necessary to postulate some mechanism by means of which the individualists of the cell population are induced to submit to regimentation." In other words, there must be the physiological equivalent of a nervous system or of a circulatory system within the colony. Marked morphological differences have been noted [1] between the surface bacteria and those near the colony center. Both structural differentiation and neurohormonal regimentation, therefore, are thus suggested. This regimentation is of theoretical interest, since it conceivably duplicates the earliest stage in the evolution of our present metazoa.

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† This department of CALIFORNIA AND WESTERN MEDICINE presents editorial comments by contributing members on items of medical progress, science and practice, and on topics from recent medical books or journals. An invitation is extended to all members of the California Medical Association to submit brief editorial discussions suitable for publication in this department. No presentation should be over five hundred words in length.

[1] Muto, T.: Centralbl. f. Bakt., Orig., 37:321, 1934.

[2] Smith, N. R., and Clark, F. E.: J. Bact., 35:59, 1938.

[3] Shinn, Lawrence E.: J. Bact., 36:419 (Oct.), 1938.

Box 51.

W. H. Manwaring,
Stanford University.

THE PHRASE, "ART AND SCIENCE OF MEDICINE"

Recent interest in semantics, or a study of the meaning of words, suggests a consideration of that well-known phrase, "the art and science of medicine." In the light of what Castiglioni[1] calls "a more and more manifest unrest" with "new tendencies of studies, research and clinical speculation," two different meanings can be ascribed to the phrase. If these are not kept in mind, misunderstandings may develop.

In one sense the terminology, "art and science," is applied to characterize the difference between practicing and research medicine. As a man of research, the clinician is considered to be a scientist; as a practitioner, an artist. As a research clinician his task is considered to consist of "accumulating data"; as a practicing clinician it is considered to consist of "judging" to what extent the accumulated "facts" (i. e., generalizations) can be used for a special purpose, for determining, for instance, whether or not digitalis should be administered in a particular case. The term "art," as used in this sense, is applied synonymously with the terms "skilfulness" and "craftsmanship." The difference between medicine as art and medicine as science, as seen from this viewpoint, is primarily a quantitative difference of precision, a difference of perfection of one single method, namely, of the method of measuring as applied in two different fields. For, however different the two goals of practicing and research medicine may be, it is only the lack of development of the method of measuring in practicing medicine, the insufficient analysis of the individual, which makes the practice of medicine from this point of view an art.

In the second sense, the term "art and science of medicine" is not used to indicate a quantitative difference, but to point out the possibility and necessity of looking from two qualitatively different angles at patients, regardless of whether in the field of practicing or research medicine. In this use of the phrase, the term "scientific" connotes the aim to judge by measuring, regardless of the encountered difficulties, while the term "art" is used to indicate an attitude of the clinician toward nature and patient, which is quite similar to that of an artist toward nature and his creation.

In art, as understood by artists themselves, the quality of the achieved result cannot be measured. It cannot be determined by comparing it against some norm or transforming it into such neutral entities as quantities and figures. Only nonmathematical conceptions, such as consistency, can reveal the artistic quality of a product of art. The quality can only be determined by comparing the achieved result in itself, with its "idea." Likewise, as understood in this most specific sense of the term "art," the healthy state of the single individual patient, as encountered in practicing medicine, can only be determined by comparing the single individual with himself, with his "idea"; for (again as understood from the artistic point of view of this second differentiation) the single individual is in-dividual; it cannot be divided and transformed into quantities and figures. And the single individual is single in the sense of unique; it has no standard with which it can be compared. In other words, the single individual is, from this point of view, not accessible to the scientific method; not judgment, but intuition characterizes the term "art," as contemplated in this second sense of the phrase. Grote, in order to describe precisely from this standpoint the state of "individual" health, coined the term "responsivity" ("Responsivitaet"), *i. e.*, corresponding with oneself. As said above, the artistic and scientific viewpoint supplement each other in this differentiation; only their common use comprehends the individual completely.[2]

It is in relation to research medicine, however, and not in relation to the single individual, to practicing medicine, that Henle, in his "Handbuch der rationellen Pathologie," refers to the artistic side of medicine, and that Virchow, in the first volume of his "Archiv," distinguishes the artistic from the scientific part. It is a double character of research medicine, similar to that of practicing medicine, which they point out and denominate by the terminology "art and science," the two tasks of research medicine: on one hand, artistically to explore the patients and their cure, to draw clinical pictures and therapeutic entities; on the other, scientifically to explain the disease and drug action, and to transform the engendered creations into physical-chemical terms; on the one hand, to emphasize exhaustion in observation and evaluation in description, to specify the studied subject; on the other, to emphasize the mechanical sequence of the observed situation and to destroy any specificity; on the one hand to apply the measuring method in order to help characterize and visualize certain individuals as a constitutional type; on the other, to apply the measuring method in order to generalize, to specialize (but not to specify) the individuals completely; on the one hand, to be permanently conscious of ever new, ever creative nature (*natura naturans*); on the other, to consider the infinity factor as rather small in medical research (*natura naturata*).

Many other terms are used to characterize these two confronting attitudes: empirical and rational, realistic and theoretic, biologic and mechanic, Hippocratic and Galenic,[3] (more) idiographic and nomothetic (the last two terms were originally coined in order to differentiate the viewpoints of history and the exact natural sciences: "to describe what once (!) has been, and to state what always is").

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[1] Neo-Hippocratic Tendencies of Modern Medical Thought. Med. Life, 41:115-146, 1934.

[2] Skillfulness and craftsmanship reveal according to this differentiation art insofar as they reveal the specificity of a given situation (as for instance, art in a performance of acrobats or art as manifested in a very thoroughly constructed machine).

[3] Hutchins' interpretation of Galenic (Surg. Gynec. & Obst., 58:420, 1934) seems rather isolated.

Comparing the two meanings which have been given to the phrase "art and science" of medicine, one will agree that the second offers several advantages over the first. It embraces the first without restricting it within itself in any way. It uses the term "art" in its most specific sense. It is also more precise from the philosophical standpoint. It realizes the philosophical consideration that the generalizations of the mechanical sciences are due to their character, insufficient to completely comprehend an experienced situation for human thinking. (Leibnitz, who assumed that all *verités de fait* have their sufficient reasons in the *verités éternelles*, postulated this assumption only for divine thinking). It calls attention to a field of research for which there is not much room in the first, and as Faber writes in his "Nosography in Modern Internal Medicine":[4] "Every time any important advance is made in this field it is considered in the clinic to be a great feat, and the description of a new disease is of extremely great importance in practical medicine. To the physiologist and the worker in the laboratory, morbid categories are subordinate concepts, but to the physician, to the clinician, the reverse is the case; he cannot live, cannot speak, cannot act without them." The second differentiation finally gives more shape to the historical aspect of medicine. The curves of the way of medical history do not seem to be so exclusively externally conditioned, so little developed by medicine itself, in the second as in the first differentiation. In the first differentiation, the way of medical history is ideally straight, and only in concrete reality bent off by more or less external obstacles; today by more than in the period just past. In the second differentiation, the way of medical history is ideally a spiral path, oscillating between art and science as it ascends, while reality only adds its deviations. And while the practicing clinician must always be equally both—and the individual research clinician usually is both—an artist and a scientist, research clinicians in general seem to prefer at given periods of history either the artistic or the scientific approach. Today we seem to be on a turning point from a scientific to an artistic period.

University of California Medical School.

Otto E. Guttentag,
San Francisco.

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[4] Annals of Med. History, 4:1-63, 1922.

Peritonitis, Not Appendicitis, Causes Death.—Patients die of spreading peritonitis, *not* because of appendicitis, John O. Bower, M.D., Philadelphia, points out in *The Journal of the American Medical Association* for January 7.

The surest method of reducing the mortality of spreading peritonitis is to hospitalize patients before their appendixes have ruptured. Routine operation as it pertains to the management of acute appendicitis and its complications, usually peritonitis, should be limited to the appendix that has not perforated. When the serous coat—the covering of the appendix containing the serum—is intact, it makes no difference whether the inflammation in the tissue beneath is catarrhal, discharges pus or is gangrenous; one patient in 183 dies.

Scientific management based on the development and the preservation of local and general immunity should be carried out when the serous coat of the appendix is ruptured.

ORIGINAL ARTICLES

EXPERIENCES WITH COLECTOMY*

By G. D. Delprat, M.D.
and
Alanson Weeks, M.D.
San Francisco

Discussion *by Alfred C. Reed, M. D., San Francisco; Malcolm R. Hill. M. D., Los Angeles; William H. Daniel, M. D., Los Angeles.*

We wish to offer for consideration four cases of ulcerative, inflammatory, and stenosing lesions of the colon and terminal ileum. One of these patients has been reported previously. These patients present three different types of colitis or ileocolitis, and are, therefore, of interest.

The first two patients, E. H. and D. S., whose clinical record will be reviewed presently, suffered from what was apparently a spontaneous ulcerative colitis with symptoms of diarrhea, some tenesmus, bleeding from the bowel, anemia, lower abdominal pain, and progressive weight loss. The symptoms were classical and the diagnosis offered no particular difficulty. Cultures from the stool showed abundant hemolytic streptococci, so that we conclude that these organisms constituted the etiological agency. The treatment was at first that customarily given to patients with tubercular lesions of the bowel, supplemented with an ileostomy to divert the fecal stream from the involved intestine. In one patient, D. S., this was sufficient to prevent further toxic symptoms (that is, as long as the ileostomy functioned); in the other patient, E. H., this palliative treatment was insufficient, and was, therefore, followed by colectomy. The third patient, J. O'N., previously reported, suffered first from an amebic infestation of the colon. The ulceration caused by the ameba, together with the reparative efforts of the bowel, produced a combination of ulcerative colitis and pseudopolyposis. When, after proper treatment, the ameba were no longer present, ulceration of the bowel continued and streptococci were cultured from the stool. This patient represents a streptococcal invasion of previously produced ulcers. Palliative treatment, with ileostomy, was insufficient to produce clinical improvement, and colectomy was performed.

The fourth patient, K. D., represents a picture that is entirely different, undoubtedly belonging to that type of ulcerative, stenosing, fistula-forming group of patients that Crohn and Ginzberg, in 1932, defined as "regional ileitis." Since 1932 many other cases have been reported, from which it is apparent that the disease defined by Crohn is not confined to the terminal ileum (as is the thirteen cases they reported), but may involve almost any part of the small and large intestine. This patient's disease was progressive in severity, and involved widely separated areas of the intestine, namely, the terminal ileum, the sigmoid and the rectum, with apparently

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Read before the General Surgery Section of the California Medical Association at the sixty-seventh annual session, Pasadena, May 9-12, 1938.

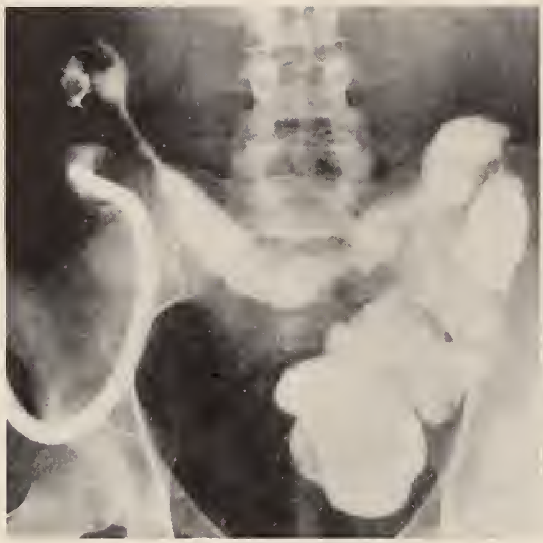


Fig. 1

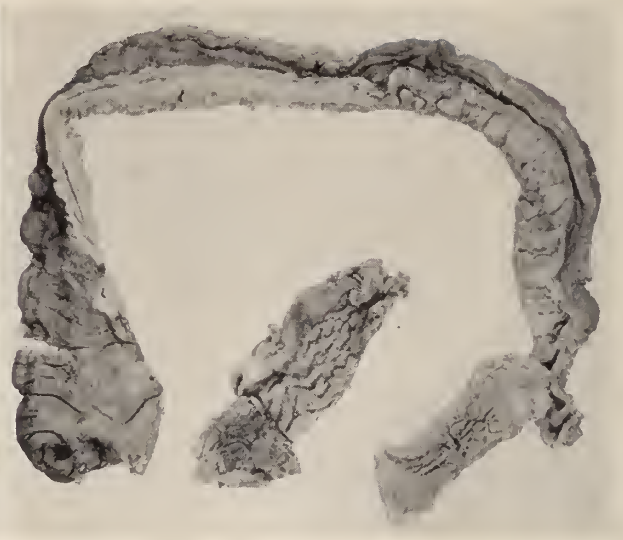


Fig. 2

Fig. 1 (Patient 2).—Barium enema was given through the colostomy opening outlining the proximal portion of the colon. The barium flows readily to the cecum without obstruction. The ascending colon and distal two-thirds of the transverse colon are somewhat spastic and smoothed out. There is a fine irregularity of this portion of the bowel, suggesting colitis. The ascending colon shows good haustral markings. The cecum is low in the pelvis, and is slightly movable and slightly tender. Conclusion: The x-ray appearance is that of ulcerative colitis of the transverse and descending colon.

Fig. 2 (Patient 2).—Specimen removed, including some portion of ileum, entire colon and anus. Rectum and anus constitute the separate portion in the center of the plate; the thickening of the colon is well illustrated.

normal areas between these lesions. After palliative measures had been performed, the disease continued to extend. First, a resection of a portion of involved ileum, then an ileotransverse colostomy, and later a complete colectomy (without the rectum), were performed. Even then the entire involved area of the terminal ileum was.not removed, and recurrence of the disease with fistula formation occurred proximal to the terminal ileostomy. Resection of another eight inches of ileum has apparently effected a cure; at least, the patient has had no symptoms of ulceration and no new fistulae in the last twelve months.

The fourth patient's history will be presented in some detail on account of unusual symptoms (tetany), which we have not noticed elsewhere in the literature.

COMMENT

In regard to colectomy, we shall state that it is an operation not to be considered lightly. Patients who need this operation for ulcerative colitis have suffered previously for a long period of time, are debilitated, anemic, and are poor operative risks. However, on the other hand, they have, to a certain extent, become immunized to the organisms that infect the bowel, and hence breaks in operative technique have not been as serious as might be expected. In all three patients upon whom colectomy was performed, soiling of the abdominal cavity undoubtedly occurred, and although the postoperative course was stormy, the patients did not develop peritonitis or abdominal abscesses. In all cases there was marked infection of the operative incision, but this apparently was confined to the subcutaneous tissues, since the fascias are firmly healed and there is no postoperative hernia.

For some months postoperatively there has been difficulty in controlling the discharges from the ileostomy. At first, these are very liquid, but in two of the patients, J. O'N. and E. H., they have become semisolid and quite intermittent. In the last patient the control of the fecal stream is still quite unsatisfactory. Discharges from the ileum are considerably more irritating to the skin surface than those from the sigmoid.

In removing the colon, in all cases care must be taken to preserve the omentum. (Presentation of slides by the authors.)

CONCLUSION

Ulcerative lesions of the ileum and colon should be treated by complete ileostomy. If the symptoms are not relieved by this procedure, complete colectomy is indicated.

REPORT OF CASES

Case 1.—D. S. Age, twelve.

1. Admitted on October 23, 1932—October 24, 1932. (Service of Best & Brooks.)

Diagnosis.—Anemia, dehydration.

Hemoglobin, 100 per cent; red blood cells, 5,800,000; white blood cells, 21,700; polymorphonuclears, 75 per cent; eosinophils, 3; basophils, 2.

2. Admitted on November 2, 1932—February 11, 1933. (Service of Weeks, Pflueger, and Delprat.)

Ulcerative colitis: secondary anemia.

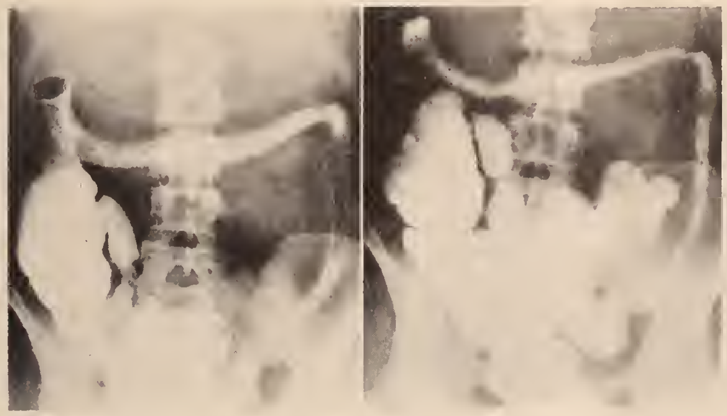
Operation: Ileostomy on December 16, 1932. Resection loop ileum projecting, February 4, 1933.

Complaint: Diarrhea since 1929.

Family History.—Negative.

Past History.—Birth and infancy normal. Normal development. Pertussis and mumps in 1925; measles and chickenpox in 1926. General health good until present illness, except for persistent constipation. Tonsillectomy in 1924. Last year (1931?) patient had an "attack of dysentery"; watery stools since. For the past few months, four to six watery stools daily, with some blood. No fever. Appetite poor. Losing weight last month.

Present Illness.—October, 1929. Two and one-half years ago patient suddenly had three liquid stools, chocolate-colored. Since that time has not had a normal movement.



Figs. 3 and 4

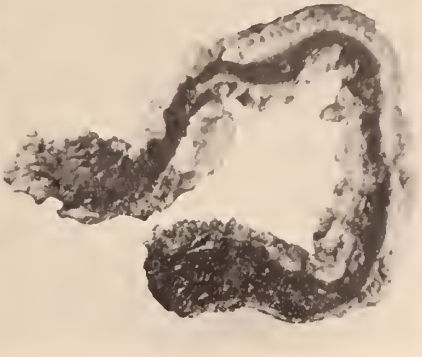


Fig. 5

Figs. 3 and 4 (Patient 3).—Heart and arch within normal limits. The lung fields are clear. The esophagus is normal. The stomach is of good tone and smooth in outline. The cap is smooth and fills well. There is no delay in the duodenum. At six hours the meal is in the terminal ileum and cecum. There is a trace of barium scattered through the cecum. The transverse and descending loops are smoothed out and narrowed suggesting colitis. At twenty-four hours there is a small amount of barium in the cecum and appendix. The remainder of the bowel is empty. The barium flows rapidly to the cecum without obstruction. The hepatic flexure, transverse and descending colon are spastic and smoothed out. There are haustral markings present. The posterior half of the ascending colon is of normal caliber. The barium runs back into the terminal ileum. The sigmoid does not appear to be involved, as it is of normal caliber. The appendix is partially filled. Conclusion: Colitis.

Fig. 5 (Patient 3).—Entire colon and cecum—on the right of the plate; rectum on the left.

Very frequently stools have had dark blood—never bright red blood. Occasionally, for a period of one or two months, she has had only one liquid movement a day. For the past few months she has had four to six movements daily. When diarrhea was bad, was much bloated and passed very foul gas. Stool also had foul odor. Had lost weight and tired easily. Easily upset, mentally. Had not had fever at any time. Had trouble keeping warm. Skin was dry, wrinkled, cracked easily during illness. Had nausea and vomiting when diarrhea was bad. Often soiled herself if unable to reach toilet in time. Never got up at night.

Physical Examination.—Fairly well developed and nourished. Appeared somewhat peaked. Nothing found except somewhat firm, slightly tender abdomen, especially along course of colon. Abdomen full, tympanitic with active peristalsis. Rectal tenderness in entire rectum.

Blood: Hemoglobin, 73 per cent; red blood cells, 4,500,000; white blood cells, 9,000; polymorphonuclears, 45 per cent.

Urine: Four to five white blood cells. Tuberculin, positive twenty-four to forty-eight hours.

Stool: Liquid, brown, some mucus, some flakes of blood. Occult blood positive; Gram-negative. Gram-positive bacteria and pus cells in smears. (*Stool culture:* Bacillus coli; moderate number of Streptococcus viridans.) Bleeding, coagulation times normal.

Proctoscopic Examination.—May 10, 1932. Mucosa pinkish, thickened with flakes of white mucus, purulent. No ulcers, but numerous pin-point hemorrhages scattered about uniformly from a depth of ten centimeters down to the columus of Morgagni.

Barium Enema.—May 12, 1932. Preliminary films of the abdomen showed some calcification in the right side of the pelvis. Colon was normal, as examined by the opaque enema. November 8, 1932. The barium flowed readily to the cecum without obstruction or defect. The bowel was quite irritable and the enema was retained with great difficulty. The haustral markings of the descending colon all smoothed out. There was some spasm of the descending colon. Conclusion: Colitis.

Course in Hospital.—The child continued with the symptom of diarrhea, abdominal cramps, occasional nausea and vomiting, from November 2, 1932 to December 16, 1932. During this period various forms of treatment were undertaken, with varying degrees of success. Diet: "Colitis diet"—cottage cheese, fermilac. Medication: Paregoric, intravenous glucose, calcium gluconate, viosterol, parathormone, liver, iron (Lilly), and sedatives. Other treatment: Diathermy to abdomen, vaccine (autogenous from bowel streptococci).

Blood Phosphorus.—November 29, 1932, 2.7 milligrams; December 12, 1932, 3.6 milligrams.

Blood Calcium.—November 29, 1932, 8.3 milligrams; December 12, 1932, 10.9 milligrams.

Bacteriological Examination of Stool.—Numerous Gram-positive diplococci with capsules, some Gram-negative cocci, few short streptococcal chains, moderate number of Gram-negative rods; no acid-fast bacteria, no cysts, ova, or parasites. Culture: No growth of lactose fermenting organisms, growth of lanceolate cocci (chained pairs, enterococci). Vaccine was made of latter.

During this period of treatment the patient's temperature, although said to be normal before entering the hospital, rarely was normal, fluctuating between 37 and 40. Pulse varied between 90 and 110. Following surgery on December 16, 1932, the temperature fell sharply to normal (without even the customary postoperative rise) and practically remained so until discharge from the hospital.

Since obviously the conservative type of treatment was hardly successful, diversion of the fecal stream from the colon was, therefore, considered.

Operation.—December 16, 1932. (Doctors Weeks and Pflueger.) Right rectus incision. There was considerable amount of clear fluid in the abdomen. The cecum was examined and, to appearance and palpation, was negative. Further exploration not done. Appendix removed. Loop of ileum just proximal to the cecum was drawn out of the lower angle of the wound. Abdomen was closed.

The projecting loop of ileum was opened the following day, and the redundant piece of ileum removed on February 4, 1933. Pathological examination of this tissue showed no abnormality.

The patient was readmitted to the hospital on April 8, 1935. During the past twenty-six months the rectal tenesmus had markedly improved. For a few weeks after discharge from the hospital there had been rectal bleeding and a foul mucopurulent discharge, but with occasional warm salt irrigations this had improved and the patient appeared to be practically well. Barium enema showed the colon to be small, somewhat spastic. It was thought that it would probably be safe to attempt to revert the fecal stream through the colon, and consequently, on May 24, 1935, closure of the "double-barrelled" ileostomy was undertaken with a right-angle clamp after the manner of Mikulicz.

As soon as the fecal stream entered the colon, however, all the old symptoms of cramps, blood diarrhea, and nausea returned. Fortunately, after a short time, the fecal stream practically all reverted to the ileostomy opening, and now the entire fecal stream passes through the ileum, which has prolapsed two or three inches through the abdominal wall.

As long as the ileostomy functions the patient is symptom free, and a colectomy is, therefore, not necessary at the present time.

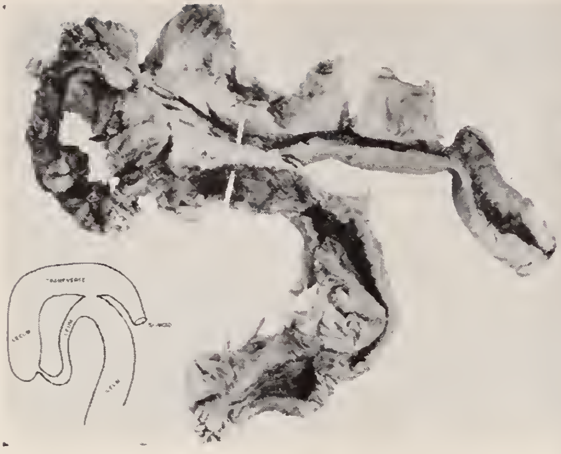


Fig. 6

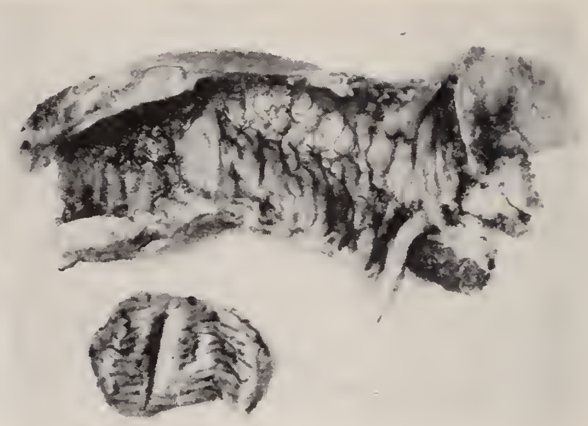


Fig. 7

Fig. 6 (Patient 4).—Specimen removed as illustrated in diagrammatic sketch.

Fig. 7 (Patient 4).—Portion of ileum removed May, 1937. Terminal ileum, showing thickening of the wall and inflammatory changes.

Case 2.—E. H. Female. Age, twenty-one.

First admission, May 2, 1933—June 18, 1933.

Complaint: Bleeding from rectum for four months. Loss of weight. Weakness.

Present Illness.—On last New Year's Day (January 1, 1933), noticed small amount oozing from rectum and anus, which occurred spontaneously and lasted a few minutes. Bleeding has continued at least once a day since, usually preceded by abdominal cramps that subside as the bleeding commences. More frequent in forenoon, after breakfast, but often also at other times. During last week, four or five times a day, and increasing amount, being about a cupful at each time. Passage consists of bright-red blood mixed with mucus. Also had a dull lower abdominal ache that was more or less persistent. No nausea or vomiting. No pain with defecation. Bowels always only moved with enemata. Loss of weight is ten pounds in last four months, and patient growing progressively weaker. She has always been well before onset of present illness.

Past History.—No familial diseases. Occupation, clerk. Weight, 130; present weight, 112. Menstruation began at the age of twelve, May, 1928.

Physical Examination. — Examination essentially negative, except for some tenderness in the lower abdomen.

Blood: May 2, 1933. Hemoglobin, 67 per cent; red blood cells, 3,840,000; white blood cells, 8,600; polymorphonuclears, 67 per cent.

Urine, negative. Wassermann and Kahn, negative.

Operation. — (Doctor Morgan.) Sigmoidostomy — right paramedian incision. Left colon edematous, injected, and showed evidence of acute visceral peritonitis. The wall was definitely thickened, although no tumors were felt. The colon just above the peritoneal reflection was smaller than normal, but the walls were thickened and the lumen definitely reduced in size. At this point a nodular gland was felt in the bowel wall. A few of the glands of the left mesentery were edematous. There was a small amount of free fluid in the abdominal cavity which suggested a streptococcal infection. The remaining colon was negative, except that the capillaries were injected. Sigmoidostomy was done through a high left inguinal incision.

Biopsy Report.—Small fragment of colon mucosa, hemorrhagic, covered with pus cells in ulcerated area. Glands slightly distorted by inflammatory reaction, but not malignant. Examination of stool showed purulent foul liquid. Occult blood three plus; mucus normal. Microscopic: Mass of red and white blood cells and bacteria. Negative for ova, cysts, or parasites. Negative for typhoid, paratyphoid, and dysentery groups.

The patient suffered a rather stormy postoperative period, during which temperature ranged between 39 and 40 for about three weeks, and then gradually reached normal at the end of the fourth week, with pulse ranging between 110 and 130. During this period blood cultures were negative, and the patient received three whole blood transfusions of 750 cubic centimeters each. On May 14, 1933, she developed a bilateral parotitis, which gradually subsided, and the patient left the hospital on June 18, 1933, against the advice of the attending staff.

An x-ray examination on May 3, 1933, concluded with the statement: "No evidence of tumor mass or obstruction. The irritable spastic appearance of the distal half of the colon suggests ulcerative colitis."

Second Admission.—August 4, 1933—October 3, 1933. Patient stated that since leaving the hospital, on June 18, 1933, she has been getting along splendidly; however, there has been some passage of blood and mucus from the rectum, but none from the colostomy wound. She has been receiving rectal instillations, and the blood is noticed only afterward. Three weeks ago, four days after the difficult extraction of an abscessed tooth, she noticed blood appearing from the colostomy. This bleeding has become more active and is now almost continuous. Hemoglobin, 63 per cent; red blood cells, 3,480,000; white blood cells, 7,700; polymorphonuclears, 50 per cent. Urine negative. Stool examinations (six specimens) negative for ova, cysts and parasites, typhoid or dysentery groups. Some 75 per cent of organisms Gram-negative. One specimen contained a budding and yeast-like branching fungus. During this period of hospitalization the patient had a fairly wide septic swing in her temperature chart, although the pulse usually remained about 90. Treatment consisted of tannic-acid instillations into the rectum, colitis diet, liver extract, carbarsone, visform, tincture of opium, and bacteriophage (prepared by Doctor Schultz of Stanford University).

Third Admission.—July 9, 1934—July 11, 1934, for treatment for anal fissure.

Fourth Admission.—June 6, 1935—June 22, 1935. Complaint of substernal pain. Treatment for colitis as above indicated.

Fifth Admission. — August 7, 1935—August 18, 1935. During interval had been treated by Dr. P. A. Taylor with barium, kaolin, dicalcium phosphate, and Haliver Oil, and has gained weight, now weighing 136 pounds. Hemoglobin, 84 per cent; red blood cells, 5,200,000; white blood cells, 15,300; polymorphonuclears, 51 per cent; eosinophils, 2; lymphocytes, 45; endothelial, 2.

Sixth Admission.—September 24, 1935—January 5, 1936. (Treatment: Ileostomy, appendectomy, September 27, 1935.) (Doctor Morgan.) Three transfusions.

Owing to the evident inflammatory lesion above the sigmoidostomy, Doctor Morgan performed an ileostomy about ten centimeters proximal to the ileocecal valve. The immediate postoperative course was good, but the patient required a great deal of intravenous therapy to offset the excessive loss of fluid from the ileostomy. Since the patient had poorly developed surface veins, continuous venoclysis was administered for several periods by means of an indwelling canula. During this time she suffered very severely with abdominal cramps, crying and writhing with pain unless given relief by opiates.

On about October 25, 1935, the patient apparently developed an acute ileitis, having elevated temperature, pulse, 13,300 white blood cells, 68 per cent polymorphonuclears, and marked vomiting, apparently of the obstructive type. Treatment consisted of continuous gastric lavage, intravenous therapy, compresses to the abdomen, and whole-blood transfusions. Under this treatment she gradually improved until her discharge on January 5, 1936.

Seventh Admission.—June 29, 1936—July 3, 1936. Felt well until one month ago, when she suffered from dull, aching pain in the upper abdomen, and the passage of more blood from the rectum and colostomy. Received 150 cubic centimeters of blood from brother, immunized with antigen.

Eighth Admission.—July 21, 1936—November 22, 1936. Operations: Transfusion, July 21, 1936; colectomy, resection rectum and anus, transfusion x 2, September 1, 1936; pyelography and kidney lavage x 6, October 20, 1936—November 18, 1936. Readmission, with same complaint of severe abdominal cramps, passage of blood through the colostomy and through the rectum. At this time the same general treatment was continued, but owing to lack of progress complete colectomy was advised.

Operation on September 1, 1936. Nitrous oxid, ether anesthesia. Operation, 8:53 to 10:25 a. m. Preoperative diagnosis: Ulcerative colitis. Postoperative diagnosis: Same. Procedure: A long, right rectus incision made to the left of the previous ileostomy, and at the lower end through the previous operative scar which was excised. The abdomen was opened cautiously, and the omentum was found adherent along the entire anterior abdominal wall beneath the incision; this was separated. The cecum was grasped and the proximal and distal loops of ileum at the ileostomy identified. The distal ileostomy loop of ileum was divided and the portion attached to the abdominal wall closed and invaginated. It was about one and one-half inch in length. This allowed some mobility of the head of the cecum, and by dividing its lateral and posterior attachments it was easily brought up into the wound. The omentum was very thin and poorly developed, but it could be separated from the transverse colon without difficulty. The lateral attachments of the peritoneum to the ascending and descending colon were divided, and the entire colon down to the point of the sigmoidostomy was resected without difficulty. At the region of the sigmoidostomy, adhesions from the previous operation, and the inaccessibility of the bowel, made this portion of the resection technically difficult. The opening in the bowel at the sigmoidostomy was suitably covered, and the resection carried down to the lower rectum. The rectum was divided with a cautery, the lower end closed with a suture, and the entire colon above removed *in toto*. Closure of the pelvic floor and immediate removal of the anus and lower rectum completed the operative procedure. The patient was transfused with 500 cubic centimeters of whole blood. Operation: Colectomy, complete; resection of anus. Transfusion—direct method.

Following the operation there was a sharp rise of pulse to 110, which slowly dropped to 90 in about eighteen days. The temperature rose to 38.5, where it remained for several days, becoming thereafter irregular—between 38 and 39.8—and again practically normal on October 1. On October 24 she began to show signs of cystitis and pyelitis, and was treated accordingly by Doctor Player, having to undergo several kidney lavage treatments.

Cultures from the left kidney urine showed, first, B. coli. and later nonhemolytic streptococci were obtained from each kidney urine. However, by November 22, 1936, she had been afebrile for over two weeks, and was discharged in good condition.

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Case 3.—J. O'N. Age, thirty. (Previously reported in the *Journal of the American Medical Association*, Vol. 107, No. 26, p. 2121, December 26, 1936.) Infection with ameba in 1925. Subsequent treatment with disappearance of ameba, but continuation of diarrhea with progressive toxemia, dehydration, anemia, and weight loss. Seen by us in August, 1935, when ileostomy was done. Symptoms not relieved, and colectomy performed on January 21, 1936.

* * *

Case 4.—K. D. This patient first came under our care in October, 1930, at the age of twenty-two. She had been well until April, 1925, when she developed malaise, coryza, upper abdominal pain, and muscle-joint pains. These symptoms persisted for a week. She then commenced to have a diarrhea of four to five stools (sometimes more), and this has persisted with short intermissions until the present time, 1938. She was able, however, to continue at school and was graduated in 1930. Commencing about May, 1925, she suffered from cramps in the arms, thighs, calves, and feet. The cramps were extremely painful, knotting up the muscles and causing much distress; and although relieved somewhat by compresses, massage, and exercise, they have continued down to the present time.

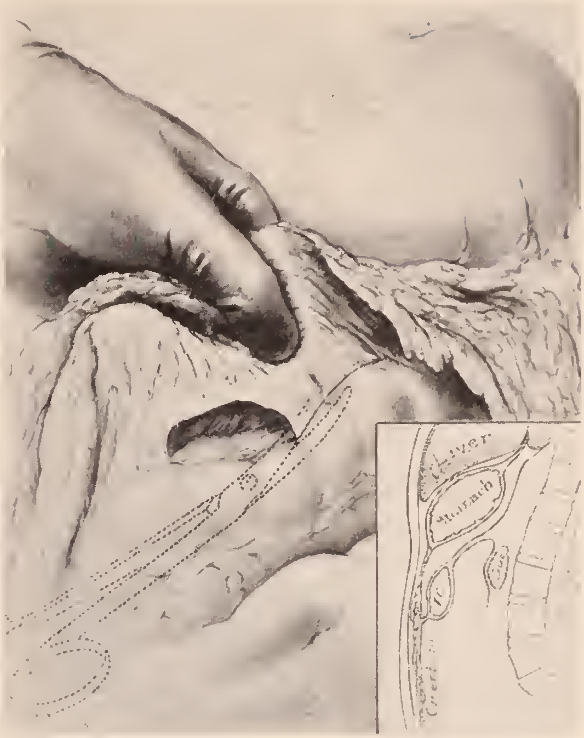

Fig. 8

Fig. 8 (Patient 4).—Separation of omentum from transverse colon.

In June, 1929, she suffered from a severe pain in the right lower quadrant, which led to the diagnosis of appendicitis for which she was operated. We have been unable to obtain the pathological findings of this operation, but the patient thinks the right tube and ovary were removed. A very stormy convalescence followed, with septicemia and abscess formation in the left buttock. Abscess was incised and drained three months. Hospitalization, two months.

On August, 1930, the patient reported to Doctor Coblentz with complaints of diarrhea, loss of five pounds in weight in a month, cramps in legs and feet. Complete physical examination was negative, except for right rectus scar, scar on left buttock, and tenderness in the right iliac fossa. No masses were felt. Pelvic examination showed virginal introitus, a fixed uterus, and fullness "like a mass" in the cul-de-sac. Rectal showed a relaxed sphincter and a few small polypi on the posterior rectal wall. Hemoglobin was 60 per cent. Urine was negative. Stool: Large amounts of mucus, few red blood cells, no ova or parasites. A diagnosis of colitis was made, and the patient was treated with kaolin and a diet.

In October, 1930, the patient developed a large, hard and tender mass beneath the right rectus scar, and was admitted to St. Luke's Hospital on our service. Bimanual palpation showed this to fill the pelvis with the consistency of a hard malignant tumor. With compressing, it seemed to soften, and in a few days a small nick at the lower end of the scar allowed about one ounce of yellow pus to escape, with much subjective relief to the patient, but with little decrease in the size of the mass. Pus culture yielded only B. coli, although smears showed a few cocci. Lipiodol injection showed by x-ray that a small sinus was present, confined to the abdominal wall. By November it appeared, from the nature of the discharge, that the sinus was connected with the small intestine, as was proved later by x-ray studies when a fistula of the lower ileum was demonstrated. Blood count at this time: Red blood cells, 4,180,000; hemoglobin, 56 per cent.

Operation.—On January 30, 1931, the patient was subjected to a laparotomy by Doctor Weeks.

Preoperative Diagnosis.—Fecal fistula.

Postoperative Diagnosis.—Fecal fistula.

Procedure.—Resection of portion of ileum, with end-to-end anastomosis.

Anesthesia.—Spinal (Doctor Lawrence), 10:47 a. m. to 12 noon.

Operation.—Incision surrounding the old scar carried down to the fascia on both sides of the fistula. Scar dissected back until only the small opening of the fistulous tract remained, and this was closed with a clamp. Clean abdominal cavity was entered through the old scar above and below this point. Thin, filmy, omental adhesions were separated, allowing the abdominal wall to be lifted from a mass of adherent loops of ileum covered with densely adherent omentum. This mass could be lifted out of the abdomen. The small intestine was very carefully separated, and a segment about 12 to 14 inches long was found to be very much thickened with old inflammation. This thickening extended well down into the mesentery. Above and below this area the intestine appeared normal. The abnormal portion was resected and an end-to-end anastomosis done, leaving about six inches of terminal ileum proximal to the ileocecal valve. The cecum and ascending colon appeared normal.

Pathological examination of the intestine showed only chronic inflammatory tissue, with no malignancy or tubercles.

The immediate postoperative condition was good, but at 4 p. m. the patient suddenly developed profound shock, the blood pressure falling in a very short time so that it no longer could be determined, the radial pulse became imperceptible, and the patient became comatose. Glucose intravenously, and a 750 cubic centimeter whole blood transfusion, however, worked a miraculous transformation, and the patient rallied as rapidly as she had failed. The following morning she felt fine, except for a backache. Convalescence was uneventful, with primary wound healing until February 10, when the temperature rose to 38, pulse to 140, white blood cells 22,000, polymorphonuclears 88 per cent, and the patient complained of pain beneath the incision. There seemed to be a fullness beneath the incision; and although a clamp was inserted beneath the wound, no abscess was encountered. A transfusion of whole blood, 500 cubic centimeters, was given. By February 16, the temperature and pulse had become normal, and on March 15, 1931, she was discharged from the hospital, with hemoglobin 49 per cent, red blood cells 3,730,000, white blood cells 5,100, polymorphonuclears 58 per cent. On April 22, 1931, the hemoglobin was 85 per cent. The abdomen was perfectly healed, felt fine, taking daily sun baths.

On April 26, 1932, the patient reported to the office, feeling listless and tired. Had noticed discharge of pus from rectum. No pain or discomfort. Examination is recorded as follows: "Mass, size of three fingers, reaching up into the perineal body within the wall of the vagina, mostly on the left side. The perineal body is tense and glassy looking, as hard as malignancy. There are two or three sinuses in it on both sides of the midline. Probe goes into the middle of the perineal body as if there were an abscess in the region. Stricture just within the anal canal. Tissues all around this very hard." Frei antigen test (lymphogranuloma inguinale) negative. Blood calcium (on account of cramp in legs and feet) normal, 9.7. Biopsy of tissue from perineum showed moderate pus and round-cell infiltration, chronic inflammation. No tuberculosis or malignancy. Treatment consisted of opening the sinuses and packing the inflamed area with gauze soaked with saturated solution of potassium permanganate, and x-ray treatment. It was soon apparent that no improvement would occur unless a colostomy was performed above the inflamed area, and on August 23, 1932, a sigmoidostomy was done. At this operation the abdomen was found free of adhesions, and inspection of the anastomosis of the ileum showed it to be in excellent condition. There were many adhesions, however, about the head of the cecum which were not disturbed. No enlarged lymph glands were noted in the mesentery. After operation, diarrhea persisted through the colostomy opening. The stool from the colostomy was thin, mucoid, and negative for blood, cysts, and pus. Bacteria nearly all Gram-negative bacilli with a few enterococci and a few staphylococci. Opiates, kaolin, bismuth and bowel irrigations did not help the diarrhea much. Probably the opiates were the most effective. Bacteriophage was prepared and given, with no improvement. Calcium in large doses did not improve the muscle cramps. For some time after the colostomy the patient was fairly comfortable. The cramps in the arms and legs were less frequent. However, after two or three months the cramps became worse, and the patient suffered severe pains in the right lower quadrant. The two complaints seemed to be related. Studies with x-ray showed partial obstruction at the ileocecal region, with distention of the ileum. (Blood chemistry studies were normal. Frei test was negative.)

Consequently, on December 30, 1933, operation was performed by Doctor Weeks, and a large inflammatory mass was found in the right iliac fossa which was very firmly attached. This was the cause of the obstruction. Many enlarged lymph nodes were noted. The inflammatory mass was not removed because of its acute character, and a ileocolostomy was performed between the normal ileum and the transverse colon. The anastomosis was technically perfect, without soiling, but within two weeks fistulae had formed leading through the recent abdominal wall, both to the cecum and to the new anastomosis. The patient was thus discharging from three places—the sigmoidostomy and these two fistulae. Biopsy from the ileum at operation on December 30, 1933, reads as follows: "Edematous wall with mucosa, showing infiltration of polynuclears and eosinophils between normal glands. Submucus coat edematous with diffuse eosinophils and round cells. Muscularis is invaded by eosinophil and round-cell infiltration along the lymphatics, and serosa contains round-cell foci. Picture is that of a nonspecific inflammatory condition without tubercles or malignancy."

In the meantime, however, the sigmoidostomy was giving trouble. The proximal loop had become hard and constricted for about three or four inches. The distal loop was large and patulous and soft. The constriction of the proximal loop continued until it would barely admit a lead pencil. Frequent x-ray studies were made, from which it appeared that the hepatic flexure, just to the right of the old ileocolostomy, would be most accessible for a temporary colostomy, which, accordingly, was done on September 21, 1935. This colostomy, however, never functioned satisfactorily, and the patient definitely was going downhill. The cramps in the legs were increasing in frequency and severity, and it was obvious the only corrective procedure that would have some fair prospect of relief was complete colectomy. Blood chemistry studies at this time were: calcium 11, phosphorus 2.8, cell diameter 6.1, volume index 65, red blood cells 5,000,000, hemoglobin 70 per cent, white blood cells 10,000, polymorphonuclears 82 per cent.

October 8, 1936—*Operation:* Gas, oxygen anesthesia. Two ounces ether. Operation, 8:43 to 9:25 a. m.

Preoperative Diagnosis.—Ulcerative colitis and ileitis.

Postoperative Diagnosis.—Same.

Procedure.—Long, left rectus incision close to the midline. There was a small amount of fat in the upper portion of the abdomen and about an inch at the lower portion. The rectus sheath was opened and the muscle displaced laterally. Peritoneum was incised and there were found to be no adhesions to the abdominal wall beneath the region of the incision. Abdominal wall was lifted up and the area inspected around the point of the sigmoidostomy, around the region of the colostomy of the hepatic flexure and in the ileocecal region, with the following findings: The terminal ileum for a distance of about two feet was dilated, and the wall was thickened, lacked tone and was indurated and grayish-pink in color, but proximal to this point it appeared to be reasonably good. The ileum was traced to the point of anastomosis to the transverse colon; from this point it was traced to the ileocecal region, but the portion of ileum between the ileocecal region and the ileocolostomy was very much more inflamed looking than in other portions. The head of the cecum and ascending colon were contracted and indurated, and formed a more or less solid mass which was adherent to the anterior abdominal wall over an area of about a half-dollar. At this point a fistula extended through the anterior abdominal wall, coming out at the lower end of the right rectus scar on the abdomen. The colon on either side of the colostomy in the region of the hepatic flexure looked reasonably normal for a short distance. The transverse colon appeared to be quite healthy-looking until one leads to a point about six inches proximal to the sigmoidostomy, and during these six inches the colon was thick, hard, contracted and rigid. The sigmoid distal to the sigmoidostomy appeared atrophic as if from disuse, but did not appear inflamed. The rectum was small, atrophic and shrunken, and the floor of the pelvis was hard, with scar-tissue formation. The uterus was in an anterior position, but was down low in the pelvis and appeared stuck in this scar tissue so that it could not be easily raised. The left ovary was down behind in the left fornix, where it was pretty well adherent. Commencing at the point where the ileum was still reasonably normal, two clamps were placed and the ileum divided by the cautery. The ileum was then dissected loose from its mesentery between ties. This portion of the mesentery of the terminal ileum was quite thick—being about three-eighths inch through—and contained numerous glands. However, ligation was undertaken across this region for fear that ligation in healthier-looking mesentery would jeopardize the circulation of the portion of ileum which was to be left in the abdomen. The lateral attachment of the cecum was divided, and the whole ileocecal region swung up out of the abdomen without much difficulty. The omentum was freed from the transverse colon and the mesentery of the transverse colon ligated. The colostomy at the hepatic flexure was cut loose from the abdominal wall and the transverse colon, and splenic flexure resected down to the sigmoidostomy. The distal loop of the sigmoidostomy was divided between clamps by a cautery, and the distal portion of this division closed over with chromic intestinal suture and dropped back into the abdomen. The sigmoidostomy was then cut loose from the abdominal wall, which therefore allowed the removal of the colon to this point and about two feet of ileum. Bleeding points were ligated. The two openings of the abdominal wall were closed, although not very effectively, because of the fact that the tissues were inflamed and extensive dissection in this area was undesirable. The abdomen was closed with continuous suture and retention sutures in the usual manner, bringing out the terminal ileum at the lower end of the wound, where it was held closed by clamps. Operation: Colectomy.

Subsequent to the colectomy the patient developed another fistula very close to the terminal ileostomy. X-ray studies showed that it communicated with the terminal ileum, very close to the ileostomy. On May 29, 1937, this condition was corrected by operation as follows:

Preoperative Diagnosis.—Ulcerative ileitis and fistula formation.

Postoperative Diagnosis.—Same.

Procedure.—Incision was made in the left abdomen, through the previous abdominal scar surrounding the fistula. By careful dissection the abdomen was opened—the fistula was found to enter into the ileum. The ileum was loosened from its attachment around, and the fistula was found entering one side of the ileum. From that point the ileum made a fairly short loop of about eight inches to the ileostomy stoma. The ileum was divided proximal to the fistula, and that portion distal to it was resected. Attached to the lateral side of the ileostomy fistula was a loop of jejunum which was densely adherent, and undoubtedly entered into the fistula. This portion of the jejunum was resected and and end-to-end anastomosis performed. The remainder of the abdomen was remarkably free of adhesions. The abdomen was closed in layers, drawing out a fairly long piece of ileum, and holding it with clamps. Operation: Resection of fistula. Ileostomy. End-to-end anastomosis.

Since May, 1937, the patient has very definitely improved in appearance, weight, and general well-being. The ileostomy has been difficult to control on account of the looseness of the movements, although paregoric, aluminum hydroxid and kaolin made some improvement. The cramps, however, have continued, although less troublesome, and we have been unable either to control these or ascertain why they occur.

Comment.—A virgin of twenty-two, after brief prodromal symptoms, develops an inflammatory lesion in the ileum with fistula formation. Resection of the apparently involved area does not cure, since the disease recurs in the perineum, cecum, and proximal loop of the sigmoid. These recurrences are not extensions of the disease from contiguous inflammatory lesions, but apparently new lesions of the same disease. Fistula formation is a striking feature of her disease. A more distressing feature of her disease is severe cramps in the legs, arms, and feet. These are unexplained. All blood-chemistry examinations have been normal. Vitamin C was found to be low quantitively at one time, but bringing this to normal did not affect the frequency of the cramps. Colectomy gave relief from sinus formation and improved the patient greatly clinically.

384 Post Street.

DISCUSSION

Alfred C. Reed, M. D. (350 Post Street, San Francisco). I have read with great interest the report of the cases herewith, which brings forcibly to notice once more the great importance of surgical treatment in chronic ulcerative colitis. It is possible that the authors have not sufficiently emphasized the point that the most difficult part of the whole procedure lies in knowing when to intervene surgically. Such intervention requires a definite idea as to prognosis, and this, in turn, depends upon exact diagnosis. Chronic ulcerative colitis is a ragbag of conditions undoubtedly very dissimilar in etiology, and from the whole group various small subdivisions are gradually being isolated. Not knowing the cause of the residual idiopathic type of ulcerative colitis, prognosis becomes most difficult and the time for surgical intervention becomes a matter of individual judgment in the individual patient.

So many cases recover completely with no treatment, and others under different types of treatment, that it seems somewhat extreme to advise complete ileostomy in all ulcerative lesions of the ileum and the colon. I wish the authors had developed this point considerably further.

It is to be remembered, also, that a complete ileostomy, just as a partial or complete colectomy, can be undertaken by skilled surgeons with successful results where under less favorable conditions operative and postoperative results are much less desirable.

I have enjoyed this presentation greatly because all possible points have been covered in it, and the results have certainly been excellent.

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Malcolm R. Hill, M. D. (727 Roosevelt Building, Los Angeles).—The report of four cases of varied interest suffering from disease of terminal bowel has been aptly presented. The authors have presented their experiences in dealing with seemingly insurmountable problems in a unique way. This in itself demands worthy comment as well as the apparent success in applying surgical treatment.

Colectomy has been and still is considered a hazardous procedure. The systematic manner in which these cases with varied complications were handled not only gives hope, but a longer lease on life to these four individuals.

Preliminary functioning complete ileostomy together with the preservation of nature's protective apron, the omentum, have been very ably emphasized. These considerations, along with undoubtedly many other details which are probably ordinary routine to these skilled operators, cannot help but make other surgical specialists envy such ability.

Anus contra nature, whether it be in the form of permanent colostomy or ileostomy, is a worthy substitute for the normal in face of debilitating disease of this portion of the gastro-intestinal tract. This is so in the individual suffering a slow insidious death, as illustrated in the four cases presented, or in the case of the individual facing demise from malignant disease.

It is hoped that this paper will encourage those in the surgical specialty to salvage more of the "human wrecks" similarly afflicted. It is essential that we sell ourselves the idea that we would rather be alive with functioning ileostomy or colectomy than a long time dead. Along with this must come personal attention to the patient, not only during surgical convalescence but as counsel and guide to them in carrying out their program of altered intestinal hygiene.

⁂

William H. Daniel, M. D. (1930 Wilshire Boulevard, Los Angeles).—The history of chronic ulcerative colitis is one of prolonged medical treatment, with remissions and exacerbations. In cases in which medical treatment has no effect on the course of the disease, it is necessary to divert the fecal stream in order to allow the lesions in the colon a chance to heal. There is no doubt that in many of these cases the colon remains as a reservoir of infection which is inimical to the welfare of the patient, and this source of infection should be removed. There has been a tendency in the past few years to treat ulcerative lesions of the colon by ileostomy and colectomy. The operation is not without hazard because of this infection, and because the patient is in poor condition when the operation is attempted. Good results have been reported bv several authors. We are well aware of the fact that polyps form upon irritative lesions of the bowel and that these polyps are prone to undergo malignant degeneration. In the removal of the colon which is infected and predisposed to polyp formation, the possibility of cancer is eliminated. Doctors Delprat and Weeks have presented a very interesting discussion of the conditions which may result in colectomy. The case report that is here presented was complicated by regional ileitis, which made the operative procedure much more difficult. They are to be complimented upon the successful outcome of the four cases presented. This work should be a stimulus to further endeavor along the same lines.

MILIARY LESIONS OF THE LUNG, ROENTGENOGRAPHICALLY CONSIDERED*

By Ray A. Carter, M.D.
Los Angeles

Discussion *by Henry Snure, M.D., Los Angeles; Milton J. Geyman, M.D., Santa Barbara; M. L. Pindell, M.D., Los Angeles.*

MILIARY appearances on the roentgenogram of the lung are of grave importance. They most often represent either a rapidly fatal form of tuberculosis or a mild silicosis. They may be produced also by many less common diseases, benign or severe, which are often not even thought of, so strong is the tendency to diagnose tuberculosis. Such lesions are expected to appear as minute rounded spots of density on the film. We may consider the diseases which produce such lesions, the factors which influence their visibility and appearance on the roentgenogram, and the differential diagnosis so far as it is available.

Miliary pulmonary lesions may be defined as minute rounded densities up to three millimeters diameter disseminated more or less uniformly in both lungs. Strictly local involvements may be excluded for the present purpose. The common criteria of roentgen diagnosis are the size, density, discreteness, and distribution of the rounded miliary shadows themselves. Increasingly, attention is paid to a fine reticulum, or network of shadows, which may accompany the "miliary" spots. Nonmiliary telltale appearances on the film and associated clinical findings are also used.

Autopsies show us that miliary lesions may fail to register on the film and that their manifestations vary from case to case, as well as from disease to disease. The reasons for this are to be sought in the pathology present, the degree of aëration of the lung, the quality of the film, and the physical laws involved in depicting densities by means of the roentgen ray.

SUMMATION OF SHADOWS

The effect of summation of shadows on the visibility and appearance of structures of miliary size has been much discussed in recent literature. One may cite the work of H. Franke,[1] Heckmann and Barth,[2] and Heckmann,[3] and summarize such effects as follows:

1. Minute foci, like miliary tubercles, are of too low physical density to record singly on the film, and do so only by summation of the shadows of several or many such overlying lesions. If the lesions are too few, there is inadequate summation and no image; if too profuse, the shadows may merge into an almost structureless haze.

2. Such reinforcement cannot be produced by a uniform overlying density, such as the soft tissues of the thoracic wall, but requires structures themselves irregular in density. Deeper layers of miliary foci, and even the normal bronchovascular structures will serve. Heckmann and Barth[2] accomplished this experimentally, using the reticular structure of a piece of zweiback.

3. Miliary lesions, so reinforced, do not appear solely as rounded densities, but in part as a fine-meshed net, or reticulum. Further, the faint normal reticulum of the lung is, itself, a summation of the overlying fine interstitial pulmonary structures.

4. Uniform filtering by overlying soft tissues may aid summation indirectly by decreasing the general film blackness from one too intense for differentiation of slight variations in density to one so reduced that the eye can detect them. Conversely, it may carry the density too low for visualization. Thus the breast shadow may either bring out or obscure a miliary appearance locally.

5. The nodules seen by summation are usually those of a relatively thin layer nearest the film. The others add little to the apparent number, and exhaust themselves in reinforcing those seen. Thus, the real number of foci is far greater than the apparent.

6. The above summations are real images, since they represent actual structures in line with the images on the film. There are also unreal images dependent upon the fact that the focal spot of the x-ray tube is broader than the miliary lesion itself. This causes the direct shadow cast by the lesion to be a slender cone, apex toward the film, called by Bronkhorst the "Kernschatten."[2] If the lesion is so far from the film that this direct shadow does not reach it, a less dense spreading shadow, the "Pseudokernschatten," extends onward to reach the film. This is surrounded by a still vaguer halo, the "Halbschatten." Sufficient of these indefinite shadows may intersect by chance to produce miliary shadows, which represent no real underlying foci, and are termed by Heckmann[3] unreal images.

7. The direct shadows, for physical reasons not detailed here, are smaller in diameter than their

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* Read before the Radiology Section of the California Medical Association at the sixty-seventh annual session, Pasadena, May 9–12, 1938.

geometric projection would indicate, and the harder the ray the narrower the shadow cast. This explains how the same bronchovascular detail appears coarse on low kilovoltage films, slender and wiry on high kilovoltage ones.

These are basic reasons why miliary lesions produce such variable proportions of fine nodulations and reticula on the film. Under the terms "mottling," "granular density," "flaking," etc., we translate such appearances into a diagnosis of miliary involvement. Also, we see the lesions are not represented accurately as to size, number, or location. Stereoscopy helps little because the shifted focal spot of the tube changes the summations. Much that is far off the film is lost, even small cavities and confluent lesions. Snure and Maner [4] have described a comparable loss of detail in bone. The smaller apices with less summation appear poorly seeded though the insemination is uniform. Diagnosis based upon the size, density, discreteness or number of miliary spots, or on the presence, absence or character of a reticulum, must be made with caution, particularly as to associated interstitial fibrosis.

OTHER FACTORS

Air contrast provided by surrounding alveolar air is a factor, as discussed by Rappaport.[5] Detail is lost by either overaëration or underaëration. The normal adult lung in full inspiration appears to provide the optimum condition for fine delineation. The low air contrast of the normal infant lung and the high aëration of emphysema both diminish it.

Technical considerations are important. The miliary appearance may be obscured by movement, over or underexposure, excessive or insufficient contrast, an overlarge focal spot in the x-ray tube, inadequate tube-film distance, coarse-grained intensifying screens, poor screen contact, or improper darkroom handling. The portable film is particularly inadequate.

The histologic composition of the lesion was considered by Heckmann and Barth [2] to have no effect on the appearance of miliary lesions. Steiner [6] found that his cases of miliary tuberculosis having epithelioid tubercles failed to record on the film, while calcification or caseation added sharply to their visibility. Dunham and Skavlem [7] rated serous exudate, cellular exudate, fibrosis, caseation, and calcification, as progressive orders of density. Neoplastic nodes in the lung are of soft density, though sharply circumscribed.

SPECIAL DISEASES

Miliary tuberculosis was surveyed for the above points in fifty-nine autopsied cases. Twenty-nine cases were juveniles, the great majority in the first five years; thirty were adults, the majority under forty; while a few were of advanced age.

No nodulation was seen on the films of eleven juveniles and six adults. No abnormal reticulum was evident in nine juveniles and four adults. These findings so coincided that, roughly, 30 per cent of juveniles and 17 per cent adults had no direct demonstration of their miliary lesions. A few of these had seedings too sparse for summation. A few portable, or otherwise substandard films, were not calculated to reveal minute detail. Most had heavy inseminations and reasonably adequate films. Some had a vague blurriness or ground-glass appearance, which might be considered, at most, suggestive. The negative film does not exclude the disease.

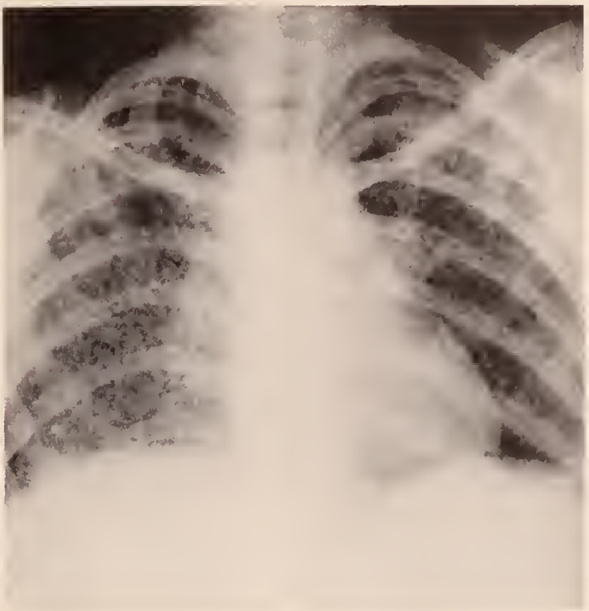

Fig. 1.—Coarse miliary tuberculosis in a child of thirteen. Nodular predominance. Obscure confluent lesions and cavities at the apices. Normal air-contrast and expansion.

Those showing real evidence of miliary involvement had varying proportions of nodular and reticular shadows. One only appeared almost wholly reticular, one almost wholly nodular. Juveniles had, on the whole, more nodular manifestations, adults more reticular. Nodulation might predominate in one part of the lung field, reticulation in another. Films viewed at some distance appeared more nodular, at reading distance they seemed more reticular. A "reticulum" was accepted only when definitely abnormally profuse. The reticulum tended to correspond to the nodules in coarseness.

There is, necessarily, a large personal factor in analyzing the characteristics of the nodulations. Our impressions were as follows. The radiographic density was low in most juveniles, high in a few. It averaged from moderate to high in the adults. Discreteness, or sharpness of outlining, was moderate to low. The size was almost evenly divided between fine (one to two millimeters diameter) and coarse (three millimeters diameter). The average profuseness of seeding was much higher than in comparable diseases. The distribution was uniform throughout the lung fields in the great majority. There were local accentuations in a few. One only was truly localized.

It was attempted to judge the air contrast by the blackening immediately about the lesions, ignoring the general impression of low contrast due to the profuse seeding. This contrast was normal in a great majority. A few had undercontrast with pleural thickening or scant fluid exudate. A few juveniles had overcontrast with seeding sufficiently profuse to imply a significant loss of respiratory

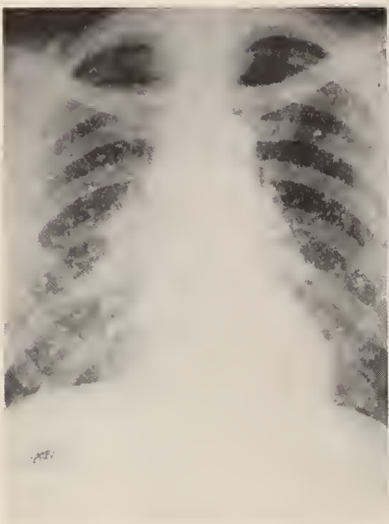

Fig. 2

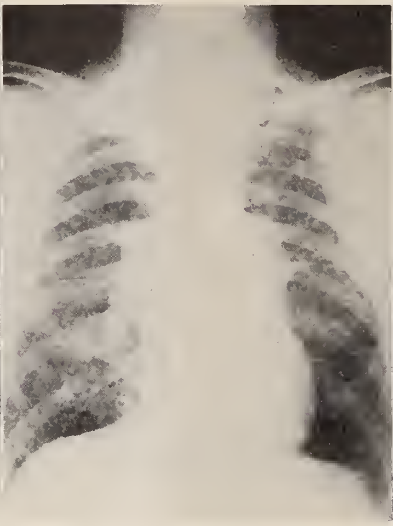

Fig. 3

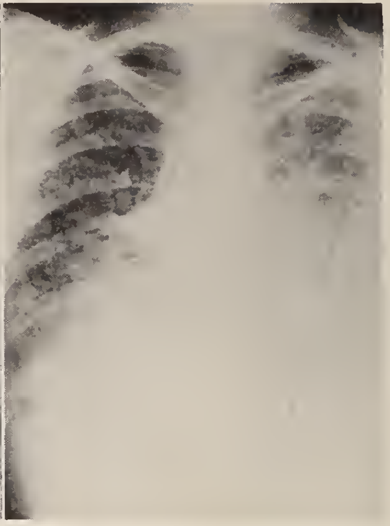

Fig. 4

Fig. 2.—Nodular silicosis with reticulation. Increased air contrast and overexpansion. Basal emphysema.

Fig. 3.—Sparse miliary calcifications. Calcification of hilar and peritracheal glands. No respiratory symptoms or tuberculous history.

Fig. 4.—Miliary carcinomatosis of bronchogenic origin. Right, basal fluid. Coarse reticulation predominates over the nodular appearances.

capacity. Pulmonary expansion corresponded to the air contrast.

Associated nonmiliary tuberculous lesions were evident in almost half the lungs. Hilar adenopathy, usually calcareous, was seen in 20 per cent of adults, and in over half of the juveniles, usually with enlargement. Enlargement of paratracheal glands was seen in 73 per cent of juveniles; paratracheal adenitis, usually calcareous, in 27 per cent of adults.

To correlate these findings: the average nodular manifestation was a uniform profuse seeding of low density and moderate to low discreteness, registering fairly clearly on a background of normal air contrast, by stippling so fine that a nodule three millimeters in diameter was coarse (Fig. 1). The smaller lesions were on the whole more profuse. These fine uniform inseminations on a background of normal or low air contrast appear unlike comparable diseases and quite characteristic, and were about half the series. Adding to these the paratracheal glandular enlargements of children and nonmiliary tuberculous appearances, the great majority would be considered tuberculous except by a real clinical discrepancy.

A minority of adults, having sparser, coarser seeding without other characteristic parenchymal lesions, have films most resembling other miliary diseases.

This series did not support the conception that acute generalized miliary tuberculosis is associated with fine profuse seeding, and less acute pulmonary involvement with the coarser lesions. Coarser lesions were seen in the acute generalized form. Very fine stippling might remain unenlarged for weeks or months. Particularly in children, small cavities, small acute "Ghons," or other small confluent lesions were often not visible, apparently lost in the miliary summations.

Chronic miliary tuberculosis, or granulie froide, occasionally occurs. It is seen, according to Saye,[8] most frequently between the ages of eighteen and thirty. It has remained quiescent as long as eleven years. It may end in resolution or in more acute disease. Minor symptoms, the miliary appearance with associated nonmiliary lesions, and enlarged paratracheal glands, may suggest the disease.

Miliary calcifications are usually thought to be healed miliary tuberculosis. Calcium metastasis has been considered. Sayers and Meriwether[9] reported 125 cases, mostly without clinical disease. They found Aspergillus in all sputa examined, but drew no final conclusion as to the origin of the involvement. The calcific seeding is so very sparse that healing would not be remarkable even though the lesions were tuberculous. The miliary calcifications are unmistakable roentgenographically, whatever their origin (Fig. 2).

Nodular silicosis may simulate miliary tuberculosis of coarse type (Fig. 3). By the time definite nodules or a sharp reticulum appears, there is usually an increased air contrast and early overexpansion of the lung unusual in tuberculosis. The bases and apices are relatively clear. The larger bronchovascular structures and hila are more thickened. The silicotic nodule is described as sharply discrete and dense. This may be partly due to heightened air contrast rather than to the intrinsic density of the nodule itself. Early silicosis may show an exceedingly fine nodulation and a reticulum more like that of fine miliary tuberculosis. Increased contrast and expansion have helped in differentiation. History is essential. In view of the known reticular summation effects, inferences of interstitial fibrosis must be made cautiously even though this is an essential part of the pathology of the disease. Silicosis also varies in manifestations from case to case. Pancoast and Pendergrass[10] comment that those seeing silicosis predominantly from one industrial source may be confused in encountering cases having a different type of silica exposure.

Silicosis with tuberculosis is usually identified by the character of the more massive nonmiliary manifestations of the two diseases. The determination from the film of how far either disease is responsible for the miliary lesions themselves is a severe and often impossible roentgen problem. Nodules with a discrete center and hazy border, extension of nodules to the apex, and lesions radiographically more advanced than the clinical disease would indicate, suggest a combined lesion.[11] Decisions in this field require close study of history and of the progress of the disease, and wide experience.

Miliary carcinomatosis may occur as metastasis from either bronchogenic or distant carcinoma. We may exclude cases in which larger nodes are scattered among those truly miliary. These larger nodes, circumscribed but not dense, are inconsistent with tuberculosis or silicosis. Those having uniform, coarse miliary nodulation may resemble either disease, particularly the coarser type of miliary tuberculosis (Fig. 4). Associated severe illness heightens the resemblance. Some of our cases have had an accompanying coarse hazy reticulum. Others have appeared almost purely nodular. The involvement tends to be basally accentuated. Hilar or mediastinal mass, atelectasis, suggestive symptoms, or a known distant primary may suggest the disease. Otherwise these cases have little to indicate their origin. Compared with nodular silicosis, the nodules are less dense and discrete, and are without surrounding increased air contrast.[12]

Coccidioidal granuloma has frequently shown profuse miliary involvement at autopsy. Usually this is represented on the film by a diffuse unorganized smearing of detail without discrete nodules or reticulum. One learns to infer the miliary involvement from this, knowing the disease to be present or seeing associated hilar and mediastinal glandular mass in the adult. Occasionally vague miliary nodulation is evident. Scattered cutaneous ulcers and/or scattered osseous lesions increase the chance of the disease in a region where it is frequently encountered. A terminal meningitis is common.

Other mycotic disease may cause miliary disease and the miliary appearance. Blastomycosis and torulosis among others may cause acute disease. Pencillium, Aspergillus, and others may produce more chronic illness.[13] It is more important to test the sputum for fungi than to attempt differentiation on the film. Terminal meningitis is common in acute mycoses and is not indicative of tuberculosis.

Miliary bronchopneumonia occasionally occurs. We have seen a few cases following measles in small children. The nodulation was coarse, uniformly distributed, hazy, sparser than the usual tuberculosis, and without evidence of hilar and paratracheal adenopathy. Post-measles miliary involvement should be given an opportunity to resolve before diagnosing it as tuberculosis, particularly in absence of adenopathy. We have seen a few adult miliary bronchopneumonias. Resolution within an appropriate period and the history made the diagnosis.

Miliary abscess of the lung in one of our cases produced a vague nodulation. Autopsy made the diagnosis.

Petechial pulmonary hemorrhage in infants producing a tuberculosis-like miliary appearance was reported by Anspach.[14] These patients had acute fatal ulcerative enteritis. Diagnosis will depend upon recognition of a clinical cause for such hemorrhage.

Periarteritis nodosa has been cited as a cause of miliary appearance.[15] This must occasionally occur, though most reported lesions appear to be of grosser type. Diagnosis depends upon prior recognition of the disease on clinical grounds.

General sarcoidosis may have miliary or larger pulmonary lesions. This or similar diseases under numerous names, such as Boeck's disease, Darier-Roussy's disease, lupus pernio, etc., may have epithelioid tubercles in almost any organ. There is considerable disagreement concerning their origin. Pinner [16] considers them tuberculous. Miliary or larger lesions are seen in the perihilar and adjacent regions of the film, not reaching to the periphery, and associated with hilar masses.[17, 18] Saacke [18] described an exceedingly fine reticular network in her case. These features, a benign course, and, if present, cutaneous nodules or cystic expanding lesions of bone, may permit recognition.

Incidental miliary appearances occur on the films of many normal chests, due to accidental miliary summations. They may be at the bifurcations of the fine vascular linear shadows, scattered sparsely, or in small clusters. Miliary disease should not be lightly assumed from such minor manifestations.

COMMENT

The miliary appearance is most frequently due to tuberculosis or nodular silicosis, occasionally to miliary carcinomatosis. Other occasional pathologic causes are so numerous that complete listing is almost impossible. Many are so rare that roentgen differentiation cannot be attempted. Even in the common ones, diagnosis from the film should be made with cautious regard for the limitations imposed by the similarity of different diseases, the variations in appearance in any one disease, and the vagaries of summation effects. History is essential. When inconsistency of symptoms or history arise, there are numerous possibilities requiring exhaustive use of all clinical and laboratory aids. Often the progress of the disease provides the clue.

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DISCUSSION

Henry Snure, M. D. (1414 South Hope Street, Los Angeles).—Doctor Carter rightly stresses the vagaries of summation effects in his comments. Summation effects were known shortly after the discovery of the roentgen ray; but frequently they are forgotten or ignored. Particularly is this true of soft tissue densities. This is in spite of the fact that it is common knowledge that, while many small gall-stone shadows can be counted on a film, the actual number of stones found at operation is usually four or more times greater.

The soft miliary densities of tuberculosis visualized on the film constitute only a small percentage of the miliary lesions present. Some lesions will be too small to be visualized on the films under any circumstances. I recall three cousins, dying of miliary tuberculosis within a few days of each other, where I had an opportunity to study the lungs in varying degrees of inflation at autopsy, and no changes were noted on the film. These miliary lesions were about a millimeter in diameter and were easily seen macroscopically.

Today, with our fine focus rotating anode tubes, fine-grain screens and faster non-screen films, a larger percentage of these cases of miliary tuberculosis are being diagnosed. We shall always have a large personal factor to contend with in interpreting fine miliary shadows or linear markings on the film, as pointed out by Doctor Carter. One man may refer to a slight accentuation of linear markings as stage one of silicosis, while the other man may refer to it as "the stage of imagination." When one attempts to compare a series of chest films made at different institutions with different voltages, and in various stages of respiration, and perhaps with a few portable films thrown in for good measure, one realizes that illusions may not be confined to the mentally deficient alone. When the history and clinical findings do not corroborate the x-ray findings, it is best to minimize the x-ray findings.

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Milton J. Geyman, M. D. (Cottage Hospital, Santa Barbara).—Doctor Carter has so thoroughly covered the subject of miliary lesions that further discussion seems superfluous. However, I should like briefly to mention two less commonly seen miliary pulmonary diseases.

While in Stockholm last year, an assistant of Lysholm, at the Royal Seraphimer Hospital, showed me an interesting group of cases of a condition which they called lymphogranuloma benignum, known here as Boeck's disease, or pulmonary sarcoid. The roentgen picture of these cases varies considerably as to the number, size, and distribution of the lesions. All of them show some degree of hilar adenopathy. The lesions in most cases show a tendency to disappear under treatment, their results being better with arsenic than with roentgen therapy.

Another lung involvement resembling miliary tuberculosis is seen in certain epidemics of measles. These lung changes disappear within eight or ten days. An embarrassing error may be avoided if this similarity is kept in mind.

I should like also to stress Doctor Carter's remarks as to technical considerations. The slightest deviation from accurate technique will preclude visualization of some miliary pulmonary diseases, and perfect films are a primary requisite in the study of obscure pulmonary conditions.

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M. L. Pindell, M. D. (670 South Ferris Avenue, Los Angeles).—This is a very timely subject, and is discussed by Doctor Carter in his usual thorough manner. Miliary type of deposits in the lungs have caused me considerable trouble and embarrassment. Not long ago I was asked to render an opinion on a film taken of a ten-year-old girl in the hospital. It was the usual miliary seeding throughout both lung fields that we so commonly see in miliary tuberculosis. She was running a high temperature, and I told her uncle, a physician, that she undoubtedly had miliary tuberculosis and would probably die within a few days. In less than a week this little girl was perfectly well—and did my face get red. She apparently had a bronchopneumonia.

As Doctor Carter states, "the negative film does not exclude the disease." About two years ago a film was taken in our department of a seventeen-year-old female, and was reported as negative. In three weeks this patient died in the General Hospital of miliary tuberculosis. A film taken two days before death showed miliary dissemination with typical summation effect. Epithelioid tubercles may have been present when the first film was taken, as the patient was at that time quite ill.

I am glad Doctor Carter has stressed the technical difficulties involved. In addition to a regular postanterior view, an anteroposterior film is sometimes helpful. Doctor Carter's plea for exhaustive clinical aid should be heeded.

SUICIDE[*]

By F. G. Lindemulder, M.D.
and
F. E. Toomey, M.D.
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SUICIDE has been both condoned and condemned since earliest times. Only since the birth of modern psychiatry have any comprehensive attempts at its prevention been made. Nevertheless, self-destruction is not decreasing. Because San Diego County has the unenviable reputation of having one of the highest suicide rates in the country, a statistical study of its 533 cases occurring in the seven-year period between 1931 and 1938 has been made in the hope that its findings might shed some light on the causes and possible prevention of suicide.

We feel that the number of unsuccessful attempts far exceeds the actual number of suicides, although there are no accurate figures on this point. Our cases include all of those in which suicide was the probable cause of death. All unsuccessful attempts and undoubtedly many cases of indirect

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[*] Read before the Neuropsychiatry Section of the California Medical Association at the sixty-seventh annual session, Pasadena, May 9-12, 1938.

From the Rees-Stealy Clinic.

TABLE 1.—*Suicide—San Diego County, California: For Period 1931-1937 Inclusive As to Methods Used*

	1931	1932	1933	1934	1935	1936	1937	Total	Per Cent
Shooting	28	27	37	29	27	30	25	203	37
Asphyxiation by illuminating gas	26	20	3	1			3	53	10
Asphyxiation by hanging	4	3	6	6	9	9	14	51	10
Asphyxiation by petrol gas	2	2	5	10	8	4	9	40	8
Asphyxiation by drowning	4	5	7	7	6		6	35	7
Jumping	6	4	2	3	8	2	8	33	6
Cutting	6	4	6	2	2	4	7	31	6
Poisoning:									
Strychnin		1	5	2	3	4	2	17	3
Arsenic	1	1	3	4	3	2	2	16	3
Cyanid		2	5	1	1		2	11	2
Mercury	2	1	1	1	2		3	10	2
Lysol	1		1		2	3		7	1
Chloroform	2		1	1	1			5	.9
Nicotin		1	2					3	.5
Amytal			1				1	2	.1
Morphin		2						2	.1
Chloroform and cyanid	1							1	.1
Strychnin and veronal	1							1	.1
Sulphonal and barbital	1							1	.1
Gopher powder		1						1	.1
Barbital		1						1	.1
Sodium fluorid			1					1	.1
Chloral hydrate			1					1	.1
Coniin			1					1	.1
Copper sulphate			1					1	.1
Phenol				1				1	.1
Formaldehyd				1				1	.1
Tincture of opium				1				1	.1
Starvation		1						1	.1
Stabbing							1	1	.1
Totals	85	76	89	70	72	58	83	533	

suicide, without the active participation of the individual, which Menninger[1] has described, are excluded.

FACTUAL DATA IN TABLES

The methods of self-destruction are shown in Table 1. Shooting accounted for the greatest number—203—and asphyxiation for the next largest number—144. Gas was the means of asphyxiation in ninety-three cases and hanging in fifty-one cases. This order of frequency of method conforms with the figures of the United States as a whole, but is the reverse of the findings of Lendrum[2] in his study of one thousand unsuccessful suicide attempts. Also, in our as in other series of successful suicides, the number of male victims far exceeds the number of females (Table 3), whereas in Lendrum's study of unsuccessful attempts there were twice as many females as males. The fact that males predominate in the successful attempts may be due to the fact that they are more apt to choose firearms, in which they are more or less proficient, as a means. Drowning was fifth in the list of methods, an interesting observation in view of San Diego's location and resultant accessibility to water.

The apparent causes of suicide are given in Table 2. Ninety-five of these victims were known to have definite psychoses; 231 were despondent, and in 164 of these ill health was given as the cause of the despondency. Our list of causes includes many reasons given in death notes, such as financial difficulties, marital troubles, unemployment, etc., in addition to factors which might have played important rôles, such as mental illness. Many of these obviously played a minor environmental rôle, but all show social maladjustment. Mühl,[3] after reviewing five hundred cases of suicide in San Diego in 1927, felt that feelings of failure and frustration were always factors in suicide.

TABLE 2.—*Suicide—San Diego County, California: For Period 1931-1937 Inclusive As to Causes*

	1931	1932	1933	1934	1935	1936	1937	Total	Per Cent
Despondent over ill health	22	21	21	22	19	28	31	164	31
Mental disease	13	25	19	21	3	6	17	104	20
Despondency	3		5	1	19	4	19	51	10
Financial worry	8	12	10	2	7	2	4	45	9
Family trouble	5	3	13	6	3	5	3	38	7
Despondent over unemployment	6	4	5	1				16	3
Alcoholism	2		4	2	2	4	1	15	3
Under arrest or to avoid arrest	3	1		2		1	2	9	2
After shooting wife or friend	1	1	1	1				4	.7
Jealousy		1		2			1	4	.7
Fear of felony conviction		1	3					4	.7
Despondent over death of loved one			1		2		1	4	.7
Family trouble and financial worry				1		1	1	3	.6
Anger					1	1		2	.3
Following abortion	1							1	.1
Fear of court martial		1						1	.1
Hysteria over loss of money			1					1	.1
Tired of living			1					1	.1
Despondent over gambling losses				1				1	.1
Worry over school examination					1			1	.1
Despondent over wife's health					1			1	.1
Worry over husband						1		1	.1
Unknown	21	6	4	8	14	5	3	61	11
Total	85	76	89	70	72	58	83	533	

The tabulation of the marital status in our series showed that more than twice as many were married as were single—274 against 110 (Table 3). Lendrum[2] found that divorce, at least among females, was a predisposing factor in unsuccessful attempts. Our figures show that thirty-six individuals were divorced and fifty-nine were widowed.

An interesting fact to note was that, whereas there were 105 different occupations represented, the majority of the suicides were among those whose employment was of a sedentary nature, such as that of housewives, retired individuals, etc. Could this be because the occupation was not suited to their needs and personality; that they were deprived of means of self-expression? The fact that even in times of depression, suicide rates in general are lowest among priests, monks, and those having out-of-doors occupations, is significant.

Only forty-two of our entire series were native Californians; from ten to twenty years was the length of residence in California of the greatest number. This is an interesting observation, even in the face of the fact that San Diego's population as a whole includes many people, both young and old, from many other states and countries. Again our figures bear out the findings of other observers that suicide is more frequent among northern European and Germanic races than among the southern European.[4] Our greatest number of foreign-born suicides was among the Germans. Our series included no individuals below ten years of age. The greatest number occurred in the fifth decade of life and the next largest number in the sixth decade. Perhaps at this age the realization that their dreams of a successful life had not materialized, made life seem no longer worth living. Or was it that these people had reached their climacteric?

A study of suicides for one year might seem to show a definite seasonal variation, but a several-year review reveals such a conclusion as a fallacy. Over our seven-year period, December had the lowest number—thirty-two—and January and July the highest, with fifty each. The distribution throughout the year over this seven-year period showed little variation. (Table 5.)

QUERIES

Is San Diego's high suicide rate due to its geographic location, the extreme southwestern area of

Table 3.—*Suicides—San Diego County, California: For Period 1931-1937 Inclusive As to Sex, Marital Status and Age*

Sex

	1931	1932	1933	1934	1935	1936	1937	Totals	Per cent
Female	20	19	19	14	14	14	14	114	21
Male	65	57	70	56	58	44	69	419	79
Totals	85	76	89	70	72	58	83	533	

Marital Status

	1931	1932	1933	1934	1935	1936	1937	Totals	Per cent
Married	43	25	45	40	40	35	46	274	51
Single	15	25	13	13	19	10	15	110	20
Widowed	10	7	13	6	7	6	10	59	11
Divorced	8	8	9	1	0	3	7	36	7
Unknown	9	11	9	10	6	4	5	54	10

Age

	1931	1932	1933	1934	1935	1936	1937	Totals	Per cent
10-20 years	1	1	4		3	2		11	2
20-30 years	10	6	8	10	9	8	6	57	10
30-40 years	9	11	18	6	13	11	19	87	16
40-50 years	19	21	16	16	16	11	18	117	22
50-60 years	14	16	16	15	11	12	20	104	20
60-70 years	22	14	16	15	6	4	8	85	16
70-80 years	8	4	7	6	7	6	9	47	9
80-90 years	1	2	3	2	6	1	3	18	3
Unknown	1	1	1		1	3		7	1
Totals	85	76	89	70	72	58	83	533	

the United States; to its equable climate, its sunshine, and high fogs; or to its large population of individuals who have come West because of ill health or because of a migrant nature, which does not permit them to adjust themselves to their environment?

Mühl[3] has given an interesting explanation of San Diego's high suicide rate in the symbolic significance of the Southwest and the attraction by the regression which it typifies, of the regressive. Mills[5] attempts to show that the suicide rate, like the morbidity rate, is influenced by various climatic factors. Although he concedes that "much of the storm effect probably works through increasing the tempo of life and economic competition," he concludes that "there probably remains a distinct disturbing action of the storm changes as they affect the body directly." However, San Diego's climate is one of the most equable in the country and is singularly free from storm changes. Whether or not more suicides occur during periods of high humidity or of certain barometric pressure levels, under the influence of storm conditions about us, our statistics do not show. Such a comparison might give us added information. On the other hand, perhaps the very equability of the climate with its enervating effect is in itself a factor.

The most logical and simple explanation of San Diego's high suicide rate seems to us to be found in the fact that a majority of the victims come to us from elsewhere. These people did not find the Utopia they expected and they were as unable to adjust themselves to their environment and circumstances here as they had been elsewhere.

AUTHORS' ANALYSIS

Our analysis of San Diego's suicide figures has perhaps shown us why its rate is higher than that of many other places in the United States. But it has added little to our understanding of suicide from a psychiatric point of view. It confirms the general opinion, especially that of the layman, that illness and feelings of failure and frustration play an active, inciting rôle; but if, with Lewis,[6] we believe that we should not assume the absence of a psychosis in any case of suicide even though there has been no evidence of frank mental disorder, and that the apparent causes are merely secondary influences, we must turn to psychiatry for the explanation and suggestion for treatment.

Table 4.—*Suicides—San Diego County, California: For Period 1931-1937 Inclusive As to Length of Time in California*

	1931	1932	1933	1934	1935	1936	1937	Total
Days to one year	9	5	6	3	7	2	10	42 (8%)
1 to 10 years	28	21	24	15	11	9	14	122 (23%)
10 to 20 years	16	15	21	26	21	18	21	138 (26%)
20 to 30 years	10	13	6	9	13	8	9	78 (13%)
30 to 40 years	5	6	1	4	5	4	11	36 (7%)
40 to 50 years	3	2	6	2	2		5	20 (4%)
50 to 60 years	1		2			2	2	7 (1%)
60 to 70 years						1	1	2 (.3%)
Life	4	3	3	3	4	7	4	28 (5%)
Unknown	9	11	10	8	9	7	6	60 (11%)
Totals	85	76	89	70	72	58	83	533

FREUD'S OBSERVATIONS

Freud has observed that there are two dominant tendencies in life: the instinct to self-preservation and the instinct to self-destruction. Lewis[6] carries the tenacity of the self-preservation instinct into the biological field when he says that "the many organic, including the vegetative processes of the body, judging from their struggles to maintain life after suicide becomes 'unconscious,' in general do not want to die any more than they do in organic disease situations where one part had regressed to the destructive breaking point." Self-destruction, on the other hand, is explained by the psychoanalysis school as a form of inverted sadism in which the individual who suffers from feelings of guilt and hate looks upon himself as the worst type of culprit or sinner. His attempts at violence on himself represent his feelings of the need of punishment.

ON THERAPY

Psychiatric treatment of the potential or attempted suicide victim deals with the correction of

Table 5.—*Suicides—San Diego County, California: For Period 1931-1937 Inclusive As to Time-Periods*

Month	1931	1932	1933	1934	1935	1936	1937	Total
January	4	6	3	7	6	1	5	32 (6%)
February	8	7	10	5	5	7	7	49 (9%)
March	2	6	5	10	7	6	7	43 (8%)
April	9	8	9	3	8	4	5	46 (9%)
May	1	9	5	7	9	3	6	40 (7%)
June	6	3	8	4	8	2	10	41 (7%)
July	5	5	13	9	3	4	11	50 (9%)
August	5	11	10	5	5	6	5	47 (9%)
September	6	7	8	8	6	6	6	47 (9%)
October	5	8	7	4	4	8	5	41 (7%)
November	11	2	4	5	7	5	11	45 (8%)
December	22	4	7	3	4	6	4	50 (9%)
Unknown	1						1	2 (.3%)
Time of Day								
A. M.	29	21	39	19	28	17	27	180 (33%)
P. M.	31	27	26	28	21	31	39	203 (38%)
Not definite	1	3						4 (.7%)
Night		2	1					3 (.5%)
Day		1		1				2 (.3%)
Unknown	24	22	23	22	23	10	17	141 (26%)

Table 6.—*Suicides—San Diego County, California: For Period 1931-1937 Inclusive, as to Nativity*

States	1931	1932	1933	1934	1935	1936	1937	Total
Alabama						1		1
Arizona					1		1	2
Arkansas			1	1			1	3
California	6	6	4	5	7	7	7	42
Colorado		2	3	1	4	1	2	13
Connecticut		1	1	1	1			4
Delaware								
Florida							1	1
Georgia		1					1	2
Idaho			1		1			2
Illinois	3	4	4	1	7	3	2	24
Indiana			3	4	2	3	1	13
Iowa	5	4	3	1	2	1	1	17
Kansas		3	3	2	1	1		10
Kentucky	4	2	2		1	3		12
Louisiana			1	1				2
Maine				1		1	2	4
Maryland		1	1		2	1	1	6
Massachusetts	2	1				1	1	5
Michigan	1	2	4	1	1	1	3	13
Minnesota	2	1				1	3	7
Mississippi	1					1		2
Missouri	3	1	7	3		3	5	22
Montana			3				1	4
Nebraska					2	1	2	5
Nevada								
New Hampshire		1						1
New Jersey				1	1	1		3
New Mexico				1		1		2
New York	5	4	6	7	7	2	9	40
North Carolina		1						1
North Dakota		1						1
Ohio	4	2	3	1	1	3	4	18
Oklahoma	2	1	1	2			2	8
Oregon	2	1	1	1		1	2	8
Pennsylvania	2	2	1	4	3	1	3	16
Rhode Island	1			1				2
South Carolina								
South Dakota	1	1			1			3
Tennessee	1	1	2		1		2	7
Texas	3	2	2	2	2	3	1	15
Utah	2		2		1	1		6
Virginia	1		1		3			5
Vermont	1		1				1	3
Washington	1		1		1		1	4
Washington, D. C.		1						1
West Virginia			2	1				3
Wisconsin	4	2	1	2			2	11
Wyoming								
Unknown	13	12	9	8	6	4	5	57

TABLE 7.—*Suicides—San Diego County, California: For Period 1931-1937 Inclusive As to Nativity*

	1931	1932	1933	1934	1935	1936	1937	Total
Austria		1			1			2
Bulgaria		1						1
Canada	3	1	3	1		1	3	12
Denmark		1	1		1			3
England	1	2	3	2	3		2	13
Finland				1			1	2
France				1				1
Germany	3	4	2	4	3	2	2	20
Hungary		1						1
Ireland	1		1	1				3
Italy				1				1
Japan		1		1	1		2	5
Holland		1						1
Mexico	1		1	2	1	5	2	12
Montenegro			1					1
Persia							1	1
Poland	1		1					2
Russia	1		1					2
Scotland					1			1
Serbia		1						1
Sweden	4		1	3	1	1		10
Switzerland		1				1	2	4
Yugoslavia					1			1

the disturbing factor in the psychic and somatic realm, or in the patient's environment. Careful study through psychoanalysis, and this, as Lewis[6] has stated, should be directed more toward the bioanalytic fields, is needed. Since the individual directs toward himself the feelings that should be directed toward others—"narcissistic regression" is the term used by Jamieson and Wall[7]—"the aggression which might be lived out upon the external world (or another person) is blocked."[7] Many suicides may be delayed or prevented by a transference of the patient's suicidal motive to a thought or individual from which he may gain comfort or a sense of security. Withdrawal of this crutch, either voluntarily or involuntarily, may throw the patient back to his original intent, but the gradual substitution of a hobby or some other interest for this support may push this intent far enough into the background to make it an ineffective force in the patient's life. In any event, self-destruction may be indefinitely postponed. We believe that such transference forms the fundamental basis of treatment of these cases.

CONCLUSIONS

An analysis of the suicide figures of the past seven years for San Diego County conforms with similar analyses made in other localities and for the United States as a whole. The high rate of suicide in San Diego County seems to be due to the large number of migrant individuals who come here from elsewhere and find themselves no better able to adjust themselves to circumstances in San Diego than they had been in their original homes.

Since, psychiatrically speaking, suicide seems to be a result of a directing inward, rather than a directing outward, of the victim's psyche, a change in the individual's interests to outward-pointing media, by transference, would seem to be the fundamental step in the prevention of potential or attempted suicide.

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AUSCULTATION OF THE ABDOMEN*

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Woodland

Discussion *by Frank E. Wiebe, M. D., Salinas; John C. Ruddock, M. D., Los Angeles; H. Brodie Stephens, M. D., San Francisco.*

AUSCULTATION of the abdomen has been practiced too imperfectly and especially too irregularly up to the present, to be esteemed at its just value. It deserves an important place among the methods of examination, and has the advantage of being put into practice immediately at the bed of the patient with the aid only of the stethoscope. It is not intended that auscultation of the abdomen alone will establish the diagnosis, but that, employed in adjunct to our other means of examination, it will give additional pertinent information and at an earlier stage. This method is of especial value in the differential diagnosis of traumatism of the abdominal region, in following the evolution of acute abdominal disease, the evolution of the postoperative course, and formulating their prognosis.

In auscultation of the abdomen there are the variations in the transmission of extrinsic sounds that some, such as Claybrook,[1] Aschner[2] and others, believe are of value; some adventitious sounds, such as peritoneal friction in plastic peritonitis, tinkling of fluids with change of position in ascites, etc., that are rare and of questionable value; and the murmurs from normal peristalsis and modifications of it, chiefly a peristalsis and hyperperistalsis. This paper will deal only with those sounds relating to peristalsis, entering into a discussion of the anatomical background, the phylogenetic cause for the reflexes as they are, the findings as noted in the normal, in the postoperative period, and in the acute abdomen, and the interpretations of these findings.

ANATOMY AND PHYSIOLOGY

The gastro-intestinal tract has been shown by Bayliss and Starling,[3] Cannon,[4,5] Alvarez[6] and others, to be to a large extent autonomous. That is, it has within itself the mechanism essential to peristalsis.

The smooth muscle alone of the gastro-intestinal wall has the power of rhythmic contractions, as witness what happens when a single strip of such muscle, free from all nerve elements, is placed in a proper salt bath. It is necessary, however, to have coördination of these muscle contractions if an orderly sequential progressive action in the gastro-intestinal muscle tube is to be obtained.

The myenteric neuroplexus (Auerbach's), located between the longitudinal and circular intestinal muscle layers, serves for the conduction of the stimuli and the coördination of the peristaltic muscle movements. The myenteric plexus has, in addition, an inhibitive control upon the forceful muscle contractions, preventing thereby local muscle spasms or prolonged regional contractures from occurring. The submucous neuroplexus (Meissner's) located in the submucosa, has to do with reception of stimuli from within the bowel, and the conduction of those impulses to the coördinating myenteric plexus.

To summarize, the smooth muscle has the inherent power of rhythmic contraction; the submucosal plexus receives stimuli from within the bowel, and conducts impulses to the myenteric plexus, and the myenteric plexus conducts stimuli for inhibition of muscle contraction, and coördinates the muscle contractions to give thereby the waves of peristalsis.

The extrinsic nerve associations are through the sympathetic system, arising in the celiac superior plexus and passing to the intestine as the splanchnic nerves, and the parasympathetic arising in the cranial and sacral branches and passing to the intestine as the vagus and sacral nerves. Both sets of nerves pass along the mesenteric vessels, the sympathetic in the subserous coat of the blood vessel and then becoming associated with the muscle directly, while the parasympathetic branches connect directly with the myenteric plexus.

The sympathetic nervous system has an inhibiting effect, slowing the peristalsis and giving relaxation to the intestinal wall. The parasympathetic, on the other hand, has a stimulating effect. The neuro-arcs, through which the stimuli may be carried, giving a reflex action, are not definitely known. Kuntz[7] says "reflexes, mediated through the extrinsic nerves, play only a minor rôle in the control of intestinal activity, yet reflex inhibition of the movements of the small intestine may be brought about by stimulation of any afferent nerve. The reflexes involved are mediated through centers in the medulla and spinal cord, and are carried out through the splanchnic nerves. Inhibition is the only effect on the small intestine which can be brought about by stimulation of afferent nerves." He states further: "Gastro-intestinal motility of certain types probably is myogenic. Whether gastro-intestinal motility of certain other types is initiated in the enteric nervous system or in the enteric musculature must at present be regarded as an open question. Certain reactions, which are commonly recognized as reflexes, are quite certainly initiated in the enteric nervous system and carried out through it."

REFLEXES

On what are our body reflexes based? The theory that the experiences of the human race, from the very origin to the present, has developed certain reflexes of defense for the survival of the race, seems tenable. As Crile[8] has said, every adequate stimulus awakens an ontogenetic (his own personal experience), and phylogenetic (experience of his progenitors) memory or association, and the nerve mechanism evolved makes an appropriate response. Each part of the body has developed specific reactions; for example, burning of the end of the finger stimulates immediate withdrawal; a foreign body in the nostril stimulates a sneeze reflex; a foreign body in the larynx stimulates a cough reflex; and in a like manner the peritoneum, from phylogenetic experiences, has certain inherent reflexes of defense.

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* Read before the General Surgery Section of the California Medical Association at the sixty-seventh annual session, Pasadena, May 9–12, 1938.

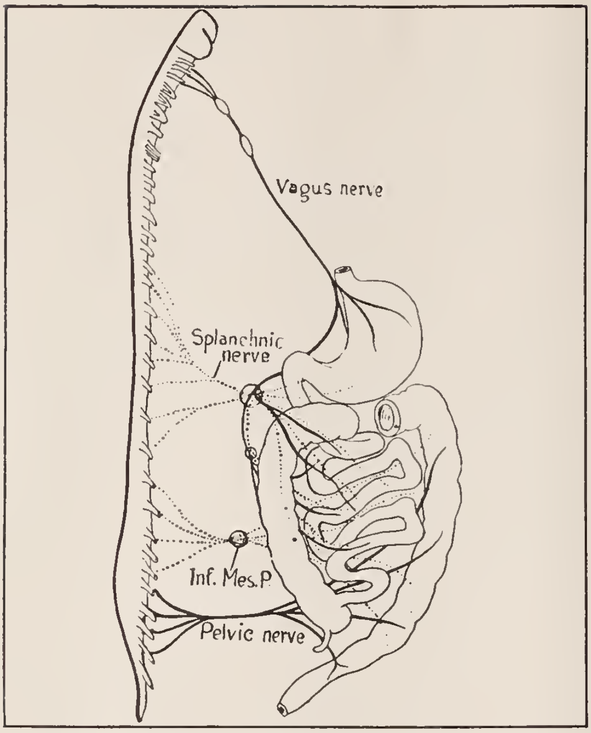

Fig. 1.—Diagram illustrating the distribution of sympathetic and parasympathetic nerves to the stomach and intestine. (Kuntz.)

The reflexes of defense on the part of the abdominal viscera and peritoneum are conditioned, as the others, on adaptation to the past environmental experience, when "man had to fight or flee." Therefore, we see these reflexes conditioned as to response, but not as to cause. The peritoneum has been endowed with powers to resist and overcome any harmful interference, such as trauma or infection, by localization. This is accomplished by reflex action where the abdominal wall is held still and rigid, the diaphragm held immobile, and the intestinal wall held still and rigid by a local inhibition of muscle contractions and intestinal distention. Now, whereas the invasion by infection or the incident of an open traumatic wound of the peritoneal cavity, or a perforation of an intra-abdominal viscus, originally was the stimulus to reaction, today modern aseptic surgery with the handling, the more or less chilling, or the use of chemicals of and upon the abdominal viscera and peritoneum, obtains the same response.

To recapitulate, there are definite defense reflexes of the peritoneum and abdominal viscera developed from phylogeny, not conditioned as to cause, but definite in response and characterized by immobilization in order to obtain localization.

One may go further and observe that, from stimuli within the gastro-intestinal tract, certain reflexes of defense for the same phylogenetic reason apparently occur, namely, any gastro-intestinal irritant, as a purge or poison, will stimulate more or less violent peristalsis in order to eliminate it. If an obstruction of the gastro-intestinal tract occurs, then a violent peristaltic action is set up. On the other hand, a foreign body in the gastro-intestinal tract will, if it tends to penetrate into the peritoneal cavity, be followed by a local quietude of that portion of bowel.

Therefore, the presence of a normal peristalsis or variation from it has a definite significance, and if by some study, such as auscultation of the abdomen, one can say as to the state of peristalsis, then more definite conclusions as to diagnosis and prognosis should follow.

PERISTALTIC SOUNDS

The peristaltic sounds as heard by the stethoscope are divided into three states:[9] (1) the state of normal peristalsis; (2) the state of aperistalsis, quietude, or absence of peristalsis; and (3) the state of abnormal or hyperperistalsis, or "rush peristalsis."

The state of normal peristalsis is recognized by the presence of normal intestinal segmental or mixing movements, myogenic in origin, characterized by soft purring, low-pitched gentle sounds, quite generally distributed over the entire abdomen, but best heard in the right lower quadrant, and more or less constant in action, dependent upon the degree of stimulation from the gastro-intestinal content. For example, after the taking of food, very active segmental motions are present for one to two hours; while, on the other hand, during the period of sleep some six hours posteating, only an occasional sound significant of motion is heard. There is also in this stage the normal peristaltic progressive movement characterized by a medium long higher-pitched gurgle, to a rumble, with occasional tinkles and gentle, squirting noises occurring at quite regular rate, and as frequently as once at least every three minutes.

The state of aperistalsis, quietude or absence of peristalsis, is as the terms denote. It is usually not complete, but may be so for brief periods dependent upon the exciting cause and its extent. One should always listen, however, for three minutes before concluding that there is a silent abdomen. It occurs definitely by an intrinsic reflex involving the peritoneum and the smooth muscle of the gastro-intestinal tract through the myenteric plexus, but may also occur through the extrinsic reflex arc. Aperistalsis is seen after abdominal surgery ordinarily up to twenty-four hours, dependent upon the degree of trauma, rough handling, chilling of tissue abnormally, injury from irritating solutions, etc., that may occur; in any instance, accompanied by irritation of the peritoneum, as peritonitis, intraperitoneal hemorrhage, intraperitoneal leakage from the gastro-intestinal tract, urinary tract or biliary tract; pancreatitis with intraperitoneal involvement and traumatic wounds rupturing into the peritoneal cavity.

Aperistalsis, on the basis of extrinsic causes, is thought to occur through a reflex that passes afferently via the splanchnics. Such extrinsic causes are postperitoneal hemorrhage; trauma, as traction or blows in the region of the solar plexus; sudden and permanent hyperextension of the spine in a body cast; sudden release of an accustomed, intra-abdominal pressure, as post-cesarean section or removal of a large intra-abdominal tumor; a crushing injury of the testis or a strangulation of the spermatic cord; torsion of an ovarian pedicle; injuries of the spine; and occasionally with ureteral calculus or subsequent to ureteral and kidney studies by cystoscopic examination.

A word should be said here as to the term "paralytic ileus." It is a term "ill chosen,"[10] probably never occurs, and is a relic term of the time when auscultation of the gastro-intestinal tract was not made. Inhibition of peristalsis or "splinting" of the bowels is the proper term, and is what actually occurs.

Abnormal peristalsis occurs in such conditions where intra-intestinal irritation is present, as from purges, ingested irritable material, poisons or foreign bodies; an intestinal obstruction from any cause; in intragastro-intestinal hemorrhage; occasionally in instances of achylia gastrica; normally in individuals of the hypertonic or vagotonic type; often accompanying the bite of the black spider; following the intravenous administration of hypertonic sodium chlorid solution; following the use of smooth muscle stimuli, as pitressin; and in instances of spinal anesthesia, where paralysis of the splanchnic nerves (sympathetic system) is obtained.

The sounds of hyperperistalsis are characterized by loud gutteral to high-pitched tones, squeaks, booms and hissing, musical sounds varying in degree, intensity and frequency, dependent upon the intestinal content of fluid and air and the cause of the irritation. For example, an acute intestinal obstruction gives at first a very vigorous hyperactive rapid peristalsis, and later, as the bowel becomes distended and fatigued, an infrequent sluggish peristalsis.

INTERPRETATION

Auscultation of the abdomen is of special value in peritonitis, acute abdominal conditions such as appendicitis, perforations of visci, intraperitoneal hemorrhage, intestinal obstruction, in differentiation in cases of traumatism about the abdomen, flanks, lumbar, and pelvic regions as to the presence or not of intraperitoneal injury, and of inestimable value in observation of the progress of the postoperative period.

In instances of irritation of the peritoneum, according to the reflexes of defense, one finds by auscultation a decrease to cessation of peristalsis. In peritonitis; appendicitis when there is neighborhood peritoneal involvement; in leakage from any viscus; from intraperitoneal hemorrhage or from external injury as an open wound, then immobilization of the intestine to protect occurs, and aperistalsis ensues. If there has been trauma in the vicinity of the abdomen, but no intraperitoneal injury, then peristalsis will be present. Active peristalsis under these circumstances would then be significant of no intraperitoneal injury and an exploratory celiotomy is avoided.

If, on the other hand, there is some intraintestinal irritant or an intestinal obstruction, then hyperperistalsis will be present. In intestinal obstruction, hyperperistalsis is at the start frequent, vigorous and loud, but at a later stage occurs at infrequent intervals, and is then of a lazy, slow, but loud type. Progressive movements are the type present, while segmental motions are usually absent.

Auscultation, in the postoperative course of an uncomplicated celiotomy, reveals most often only occasional peristaltic sounds up to twenty-four hours, and not infrequently no cessation of peristaltic sounds whatsoever. During this initial period of aperistalsis, fluids taken will remain in the upper gastro-intestinal tract and lead to gastric distention and regurgitation, and possibly vomiting. If, therefore, one listens and only when peristalsis has become relatively active, starts fluids by mouth, he will not have the frequent upper gastro-intestinal distress. Frequently enemata are given to relieve gas, believing there is some "paralytic ileus," whereas auscultation of the abdomen will usually reveal an active peristalsis and the enema as unnecessary. In addition, the enema frequently but temporarily upsets the returning smooth muscle coördination as well as the patient's morale, and besides creates unnecessary work for the nursing staff. Pitressin or other smooth muscle stimulants are given to provoke peristalsis when, if auscultation were employed, there would be revealed peristalsis already progressing satisfactorily and, therefore, no need for this whipping up of smooth muscle action guided by reflexes of phylogenetic development.

Auscultation of the abdomen gives us definite and earlier knowledge of the return of gastrointestinal function, when fluids and food by mouth may be started, and when the rectal tube to overcome anal sphincter tonicity is indicated. If there are complications occurring, as a local peritonitis or an unsuspected intestinal obstruction, then an inhibition of peristalsis or hyperperistalsis (as the case may be), will be present, the condition more promptly recognized, and the proper postoperative care adjusted.

REPORT OF CASES*

CASE 1.—W. C. H., No. 30781. This case is presented for the observance of a normal postoperative course. A female, age twenty-nine, with an apparent pregnancy of three months, accompanied by irregular cervical bleeding, "spotting," experienced, at two months, severe lower abdominal pain and an acute pelvic tenderness which persisted, although at a milder degree. Physical examination revealed a uterus of apparently two months' pregnancy, no uterine bleeding, and a retro-uterine firm, slightly tender, nonmobile mass filling the Douglas pouch. The Aschheim-Zondek test was positive at one and a half months of the pregnancy, and questionable at three months' period. The diagnosis was a tubal pregnancy complicated by probably nonviable fetus, and was so proved. Treatment consisted of celiotomy, left salpingectomy for an intratubal pregnancy, and appendectomy. There was no undue exposure of viscera. Recovery.

Comment.—This case record is illustrative of a celiotomy with considerable surgery and a smooth postoperative course. Twenty-four hours postoperatively there was beginning peristalsis, but not as frequent or sustained as normal, generally distributed, and unaccompanied by any nausea or vomiting. This signified that gastro-intestinal movements were present, and could carry gastro-intestinal content on to a partial degree only. Limited fluids were allowed, and during the next twelve hours the patient took by mouth 970 cubic centimeters. The second twenty-four hours was characterized by a decrease in peristaltic activity, and a coincidental occurrence of some nausea and slight distention. Fluids by mouth were, therefore, stopped and supplemented by intravenous glucose. The third twenty-four-hour period was characterized by a return to an active and normal peristalsis, no further nausea, and passage of flatus freely. This active peristalsis suggested that the "reflexes of defense" from whatever cause, presumably the trauma of surgery, were past. From then on the patient's convalescence was uneventful, peristalsis normal, and all fluids after the second day were taken entirely by mouth without distress.

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* Only two of twelve case reports submitted with the author's paper are here given. Others will appear in the reprints.

Thus the observation of the presence and the type of peristalsis indicated when fluids could be taken by mouth, when they should be limited, and when they could again be started and continued.

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Case 2.—W. C. H., No. 30780. This case is illustrative of an instance of peritonitis and the relation of peristalsis to this. A female, age twenty-two, experienced a gradual onset of a persistent, steady, nonradiating lower abdominal pain, worse with movement, accompanied by diarrhea at the start, vaginal discharge, marked general malaise, and nausea and vomiting. Physical examination revealed, at the start, lower abdominal general tenderness without any muscle guarding; bilateral pelvic masses with marked tenderness; and a temperature of 103 and pulse of 120. From the sixth to the tenth day there occurred some distention with lower abdominal muscle guarding. The final diagnosis, and so proved, was acute pelvic inflammatory disease with pelvic peritonitis. Treatment consisted of rest, Fowler position, ice bags to abdomen, long, hot vaginal douches, fluids intravenously and subcutaneously, especially during the sixth to tenth days of illness, celiotomy on the twenty-first day with bilateral salpingostomy and appendectomy. Recovery.

Comment.—Case 2 is illustrative of an occurrence of peritonitis and the corresponding defense reflexes. This patient's condition was considered to be an acute pelvic inflammatory disease and later, before surgery, as a probable pelvic appendicitis with abscess formation. At the start, for six days, there was active peristalsis, accompanied by no abdominal spasticity and only a low abdominal tenderness. Then the patient became more ill, had aperistalsis with accompanying moderate distention and tenderness of the lower abdomen. This condition continued for four days when, coincident with a return of peristalsis, to just over the pelvis, she showed general improvement and recession of the tenderness. By the twentieth day, postonset, normal peristalsis was well established and there was no further abdominal tenderness or spasticity, and only a remaining tender mass in the right pelvic adnexal region. Her temperature returned, likewise, to normal.

The peristalsis present and active during the first six days occurred while the findings were of an acute inflammatory process entirely limited to the pelvic cavity. On the sixth day, however, peristalsis suddenly ceased, and coincidentally there occurred abdominal distention, slight abdominal muscle guarding, and a general toxic state. This represents the occurrence of a spreading lower abdominal peritonitis, with demonstration of the defense reflex to wall off the spreading infection, namely, aperistalsis, distention and abdominal wall muscle rigidity. On the tenth day peristalsis began and, coincidentally, the abdominal distention decreased, the temperature lowered and the patient's general condition improved. This represents a conquering of the peritoneal invasion, no further stimulation of the defense reflexes, and a return to normal smooth muscle function.

The entire clinical course was followed by auscultation of the abdomen and treatment employed as indicated; that is, during the aperistaltic period fluids were withheld by mouth and given by the intravenous and subcutaneous methods, and a Levine gastric tube for gastric drainage employed for a brief period. When normal peristalsis returned, fluids, and later food, by mouth were gradually allowed.

Afterward the patient was operated upon, and the evidence found revealed the occurrence of a pelvic inflammatory disease with definite "walling off" by recent interintestinal and omental adhesions of the process to the pelvic cavity.

CONCLUSIONS

1. Auscultation of the abdomen is a method of examination of definite value and should be employed in adjunct to the other means of examination.

2. The presence and type of peristalsis, or the absence of peristalsis, is of significance in interpretation of any intraperitoneal irritation.

3. The inhibition of peristalsis is a reflex of defense on the part of the body to a peritoneal insult.

4. The application of the value of auscultation of the abdomen, as regards typical conditions directly or indirectly related to peritoneal injury, are given and discussed.

Woodland Clinic.

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DISCUSSION

Frank E. Wiebe, M. D. (610 Salinas National Bank Building, Salinas).—Doctor Woolsey has, in his usual clear and direct way, presented to us the little-used method of abdominal examination. He has discussed the anatomy and physiology involved, and has pointed out the peritoneal reflex producing inhibition of peristalsis, this reflex being initiated by any irritation, which may be chemical, mechanical, or inflammatory.

Since it has been my privilege to review this paper previously, we have taken advantage of abdominal auscultation, both for diagnosis and for following our patients postoperatively. Our most unusual impressions have been in cases of acute appendicitis in which, as the author has stated, peristalsis is inhibited in the right lower quadrant, due to an inflammatory peritoneal reflex.

A case in which we felt the clinical and laboratory findings outweighed the findings of abdominal auscultation, and which was diagnosed as acute appendicitis, proved the value of this sign. A five-year-old child, ill about ten hours with abdominal pain localizing in the right lower quadrant with definite right lower quadrant tenderness and muscle protection and rebound tenderness. The white blood count of 20,000 with 82 per cent polymorphonuclears, but with peristalsis active over the entire abdomen including the right lower quadrant, was diagnosed as acute appendicitis. On operation, we found an appendix only slightly inflamed, but in the region of the terminal ileum were a number of large red glands.

Postoperatively, we have been impressed with the absence of distress in our patients since we have been permitting only minimal amounts of fluid by mouth until peristalsis had begun, food being withheld until peristalsis has become active.

I want to thank Doctor Woolsey for presenting this method, and feel that anyone who has not utilized it will find it a valuable addition to his method of examination.

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John C. Ruddock, M. D. (1930 Wilshire Boulevard, Los Angeles).—The art of the practice of medicine which, in the absence of mechanical aids, was highly developed in our forebears, has been sadly neglected. Much dependence and finality is placed upon the findings of the roentgenologist, the hematologist, the chemist, and the bacteriologist to make the diagnosis. The five senses of man have been relegated to a minor position. Doctor Woolsey has called our attention again, and pointed out the value in diagnosis and the determination of course of treatment on the simple procedure of auscultation of the abdomen. No expensive equipment is necessary. No time is involved in the interpretation or decision. Every doctor has a stethoscope and is trained in its use. Interpretation of the intra-abdominal pathology is dependent on the physiological response to the reflex stimulated by the lesion, *i. e.*, peristalsis of the intestine. The art of the practice of medicine by applying one special sense—hearing.

Auscultation of the abdomen becomes of value in differential diagnosis in acute coronary thrombosis with abdominal splinting, or early lobar pneumonia and diaphragmatic pleurisy with reflex aperistalsis. Mesenteric thrombosis usually presents problems calling for all the skill and ancillary methods at the disposal of the clinician. Small amounts of ascites often give the patient a feeling of distention, but auscultation will reveal normal peristaltic sounds.

Many abdominal conditions when suspected are more clearly defined and localized if the simple procedure of auscultation is done. No abdominal examination is complete unless the stethoscope is used as a part of such examination.

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H. Brodie Stephens, M. D. (384 Post Street, San Francisco).—Doctor Woolsey, in his customary manner, has presented to us a valuable contribution. He has called to our attention the many aids provided by the intelligent use of the stethoscope; he has particularly stressed the use of this instrument in helping the surgeon arrive at a correct diagnosis of various intra-abdominal diseases, as well as the successful management of the patient following operation.

While hearing Doctor Woolsey's presentation, the oft-time repeated words of the late John B. Deaver came back to me. When speaking of the silent abdomen, which follows the intraperitoneal rupture of an acute suppurative process within the appendix, Doctor Deaver would relate how the surgeon should frequently listen to the abdomen through the stethoscope. In his masterful and dramatic manner he would exclaim, "And now the tinkle of peristaltic waves becomes audible, which means the peritonitis is subsiding, and this indeed is music to the surgeon's ears!"

Doctor Woolsey has justly stressed the great value which lies in this simple method of physical examination. All of us, no doubt, tend to neglect the use of our eyes and ears when we have so many modern laboratory aids at hand. This neglect will certainly do the patient no good and may do him much harm.

It had not occurred to me before hearing Doctor Woolsey's paper how accurately one actually is able to follow his patient's postoperative course by the daily use of the stethoscope. Certainly, we have here an honest indication of what the gut is really doing. Doctor Woolsey is probably very correct in telling us we could dispense with much of our postoperative treatment if we would only use the stethoscope more frequently and intelligently.

A paper such as we have just heard seems to me to be a good one to keep close at hand, one to be read every six months or so. I feel certain that after each reading we shall be better doctors and less dependent on the laboratory.

In closing, I should like to congratulate the author for his excellent paper and to congratulate his patients, too. I believe them to be lucky people!

CALIFORNIA STATE HOSPITALS*

THE PROBLEM OF OVERCROWDING

By Aaron J. Rosanoff, M.D.
Sacramento

This meeting has been called mainly for the purpose of laying before you a plan of attack on the problem of overcrowding in State hospitals; for even a partial and hasty survey of the institutions in our Department has revealed this problem as the largest and most urgent one among those that present themselves at the present time. I need not cite the statistics, which are but too well known to you all. The great fact is that our overcrowding is so great as to be physically and mentally unhygienic, esthetically revolting, and altogether intolerable.

PROBLEM OF OVERCROWDING

This problem is neither new nor peculiar to the State of California. On the contrary, it has existed now for fully a century, in more or less marked degree, in practically every state in the Union. The obvious lesson to be learned, not only from our own experience, but also, and even more impressively, from that of older and more populous states, is that the building of new hospitals, or the enlargement of existing ones, or both, no matter on how large a scale, seems to afford but partial and temporary relief at best. Every state in the Union has had under way for many years an almost continuous program of hospital construction; and none has as yet gotten caught up with its overcrowding.

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* From the office of the Director of Institutions, State of California.

Read at a special meeting of medical superintendents and social workers, held at the Stockton State Hospital on January 10, 1939.

Accordingly, the question arises, Is it possible to devise a new and more effective policy for dealing with this problem? The plan which I wish to lay before you today assumes that this question may be answered in the affirmative, and represents an attempt to outline such a policy.

AVAILABLE RESOURCES

To begin with, we have now available something over $4,300,000 for major construction in our California institutions; and in the Governor's budget for the next biennium $4,000,000 additional is requested, and will probably be appropriated by the Legislature. Out of this total something over $4,500,000 is to be used for buildings to house patients. In this way our institutional capacity is to be increased by about 3,000 beds, at an average cost of about $1,500 per bed. I believe that this money can be made to go farther in regard to increasing our bed capacity, namely, to gain 4,000, instead of 3,000 beds, without in the least compromising the principle of Class "A" construction. The changes in plans that will be necessary in order to accomplish this will, of course, be fully discussed both with the superintendents of the respective institutions and with the State Architect.

TWO ACUTE NEUROPSYCHIATRIC UNITS PROPOSED

The second feature of my plan consists in the establishment of a 200-bed acute neuropsychiatric unit in connection with the University of California Medical School and Hospital in San Francisco; also, later, a similar one in Los Angeles. The Governor has consented to include in his construction budget for the next biennium $500,000, over and above the proposed appropriations already mentioned, for this purpose; and the University of California has offered to grant to the Department of Institutions a 99-year lease on a part of its land, which is admirably suited for such a unit.

FUNCTIONS OF AN ACUTE NEUROPSYCHIATRIC UNIT

A detailed discussion of the many functions which might be performed to good purpose by an acute neuropsychiatric unit located in a metropolitan area would be irrelevant in this connection. Suffice it to say here that, with the aid of its outpatient department, such a unit would greatly facilitate the recognition of mental disorders in their incipiency, and the application of appropriate treatment at a time when it would often be effective. I have in mind especially the employment of insulin-shock therapy, or metrazol therapy, or combinations of both, in schizophrenic and manic-depressive cases; malarial inoculation or other forms of fever therapy in cases of asymptomatic neurosyphilis, and the like.

This, if carried out on an adequate scale, should have the effect of materially reducing the admission rates of the most important psychotic groups. The State will then no longer maintain its institutions as mere passive receptacles for end-products of psychotic disease committed to them for custodial care as a desperate measure of last resort.

EXTRAMURAL CARE OF MENTAL PATIENTS

The final feature of my plan calls for a large-scale extension of extramural care of mental patients. At the present time about 2,800—which is 11 per cent—of our State hospital patients are out on parole. These consist, for the most part, of patients who have recovered, or have improved sufficiently to be able to return to their homes and to their work. Experience has shown amply that in many chronic cases, too—cases in which recovery would be quite out of the question—the patients can be helped toward an adjustment on parole in self-sustaining employment. It may be estimated conservatively that in this way the percentage of cases on parole can be raised from 11 to 20, or, in actual numbers, from about 2,800 to about 5,000.

INSTITUTIONS FOR THE FEEBLE-MINDED

What has been said concerning the hospitals for psychotic patients applies, to at least an equal extent, to the institutions for the feeble-minded as well. Thus, the outstanding fact in the existing situation is that the daily average of patients on parole can be increased from a total of about 3,500 to one of about 6,000.

SOCIAL SERVICE PERSONNEL

There is, however, but one way of doing this satisfactorily, namely, by greatly increasing our social service personnel. We would require for this purpose, I believe, not only highly qualified and technically trained senior social workers, to have charge of this activity, and junior social workers to assist them, but also large numbers of field workers to be placed under their direction. The field workers for the extramural work would correspond in rank, perhaps, to the attendants whom we employ for our intramural work.

We have now, altogether, sixteen social workers in our service. I am happy to be able to report to you that I have obtained the Governor's consent to include an item of $160,000 in our budget for the next biennium for the employment of thirty-six field workers in the social service departments of our institutions. It is estimated that this should result in a net saving of $940,000 in maintenance cost of patients during the biennium.

But the benefits of such an activity would be not only of a financial character. Generally, in properly organized and supervised extramural care, the patients are happier, the people with whom they live and work are pleased, and the institutions gain something more than relief of their overcrowding.

AUTHOR'S EXPERIENCE WITH PLAN

In an experience of this kind, had a number of years ago in a large State hospital in New York, I personally selected, by a fine-combing of all the wards of the hospital, the best working patients in an intensive drive for extending extramural care. There was much grumbling on the part of some supervisors, attendants, cooks, dining-room employees, shop foremen, farmers, and others, who depended so much on the labor of these patients. Nevertheless, the plan was carried out; and pretty soon a situation arose wherein the employees were confronted with the alternative of either themselves undertaking the work previously done by patients, or breaking in other patients to do it—patients who had previously been idle and perhaps even untidy and destructive to boot.

In the face of this tragic alternative, all our employees, including the most untutored, soon became practical experts in occupational therapy and quickly rehabilitated large numbers of previously idle patients, converting them into excellent workers. That they did it by dint of bribery with tobacco, candy, extra helpings of food, special privileges, money, etc., and even by stooping to gentle diplomacy, is perhaps a sad commentary on the sordidness of human nature, as it manifested itself, in this instance, in both the employees and the patients. As for me, I had not the slightest compunctions; I felt that the end justified the means; and I have never offered an apology to anyone when it turned out, eventually, that a second crop of patients suitable for parole had been found among the newly trained workers.

FIELD WORKERS AND FAMILY CARE

An increase of our social service personnel, particularly by the addition of a large rank-and-file group to which I have referred as field workers, will, I trust, lead to another type of development of extramural care of mental patients, namely, the so-called family care. This consists in boarding out from one to five or six patients for care in private homes by an arrangement whereby the State pays a rate approximately corresponding to the per capita cost of maintenance in the institutions. The patients selected for such care are from amongst those who are too disabled physically, mentally, or both, to earn their board and room. On many farmsteads the cash income from such a source is greatly appreciated.

NEW YORK'S EXPERIENCE

A full discussion of the important and complicated subject of family care of mental patients could hardly be undertaken here. I would recommend for your careful perusal a very practical book on this subject recently published by Horatio M. Pollock, the statistician of the New York State Department of Mental Hygiene.

Over a thousand patients now receive such care in the State of New York, although this system has but recently been started there. It has been in operation for many decades in Massachusetts and in Scotland; and in the famous village of Gheel, Belgium, it constitutes the main industry of the community.

REIMBURSING PATIENTS

A point of some importance, in more respects than one, that should be considered in connection with the general subject of extramural care, is that of the possibility of arranging for the parole of certain reimbursing patients with a view to transferring them from the State hospitals to licensed private institutions. At the present time, for example, the total bed capacity of the private institutions is 3,120; the census of patients in them is 2,213; leaving 907 available vacant beds. The total number of reimbursing patients now in the State hospitals is 3,258. Of them, nearly 600 are paying more than $20 per month, which is the standard reimbursing rate, over 200 paying $40, which is the maximum that the State is permitted to charge under the law. No doubt, some could pay more.

In many of these cases, although probably not in all, an advantage would be gained all around, *i. e.,* for the patients, the State hospitals, the private institutions, and others concerned, if such a transfer were effected.

IN CONCLUSION

This concludes, in general outline, my statement of the proposed policy for dealing with our problem of overcrowding in the institutions of the Department. I should like to have you note especially that none of the features of my plan is new, or experimental, or conjectural. All of them have been thoroughly tried out in various places in this country and throughout the world over periods of years or even decades. What is new is the proposition to organize their operation in the State of California in a fully comprehensive manner.

For this purpose, each of us gathered here today, and each of those who are working under us, should act not so much as an independent unit, or one representing merely a local interest, but rather as a smoothly and effectively functioning element of a larger, more complex, and more important entity—a closely integrated Department of Institutions.

It goes without saying that such a plan as I am proposing cannot be put in operation all at once. I am sure it will require years for its full development. But it will not take care of itself. It will require harmonious coöperation, unity of purpose, and continuous effort on the part of each one of us. You will understand, therefore, my reason for taking it up with you at the very beginning of my service in office.

In so far as there may be differences of opinion among us concerning the fundamental features of the proposed plan, this is the time to have a free and full discussion of them; for at this meeting I should like very much, if possible, that we reach a decision on them by at least a majority of the executive officers of our institutions. When such a decision has been reached and recorded, I feel that any controversy which may have existed concerning the issues involved should henceforth be stilled. Every individual and every institution should then closely and loyally adhere to the policy thus adopted. In the future, any modification of policy, if found necessary, should be permissible only by a decision of a majority of the executive officers of our institutions, arrived at in a manner similar to that which we are pursuing today.

Department of Institutions.

IMMUNIZATION PROCEDURES*

REPORT OF THE COMMITTEE

By E. B. SHAW, M.D.
San Francisco
PAUL HAMILTON, M.D.
Alhambra
AND
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Oakland

YOUR committee, in formulating this report, has restricted itself to a consideration of active immunization; those methods which are utilized in health for the production of a permanent or semipermanent resistence to a specific infection. These procedures have been divided into (1) those of proven value which should routinely be done; (2) those which may be done for special indication; (3) those in which available evidence indicates that they should not be used.

I. PROCEDURES WHICH SHOULD ROUTINELY BE PERFORMED

Every child should be vaccinated against smallpox and immunized to diphtheria.

Smallpox Vaccination.—Smallpox vaccination should be performed at an early age and is ideal at six months. Between six months and two years of age, reactions to vaccination are minimal, and there is practically no danger of postvaccinal encephalitis. Vaccination should preferably be performed on the arm after thorough cleansing of the skin. There is less risk of infection in arm vaccinations, and if the site chosen is the posterior medial aspect of the upper arm, the resultant scar is extremely inconspicuous. In girls, great care should be taken to place the vaccination well out of sight under the arm. There are several methods of vaccination, but the best consists of placing a drop of glycerinized virus at the prepared site, and making several tangential strokes into the skin through the drop of virus. A single puncture will often produce a successful vaccination, and no more than ten strokes is necessary for first vaccination. It is permissible, perhaps preferable, to apply no dressing whatever; but the vaccination may be very lightly covered by several thicknesses of gauze which are loosely affixed to protect against scratching by the child. The vaccination should be inspected and dressed in one week, at which time the application of a mild antiseptic, such as tincture of merthiolate, helps to cut down subsequent infection. It is important that tight dressings of any kind be absolutely avoided.

Revaccination should commonly be done when the child first attends school, or when epidemics occur, and at intervals thereafter of from five to seven years. Revaccinations should be inspected in forty-eight hours in order to observe the accelerated take which is evidence of immunity. A vaccination which shows no reaction of any kind, either at forty-eight hours or at one week, does not indicate that the patient is immune to smallpox. All considerations of safety indicate that first vaccinations should be done in infancy, and not be deferred until school attendance.

Diphtheria. There are several satisfactory methods of producing immunity, but three injections of formolized toxoid give such excellent immunity that it is the method of choice. Two injections of ½ and 1 cubic centimeters, at three or four-week intervals, give nearly as good results. As a public health procedure, the percentage of immunity is so high it is not necessary to confirm it by the performance of a Schick test; but in private practice it is better to demonstrate immunity by a Schick test done three to six months after immunization.

Alum toxoid, in a single dose, does not give a corresponding degree of immunity, and repeated doses of alum toxoid have no advantage over formolized toxoid. A single dose of alum toxoid, followed by a dose of formolized toxoid in three or four weeks, is an acceptable procedure, and has some advantage in the speed with which some degree of immunity is produced. Toxin-antitoxin mixture is much less effective, but may be used in adults or older children who react to ordinary toxoid. The preferable method, however, of immunizing older children and adults is by the use of a series of smaller doses, beginning with 0.1 cubic centimeter, avoiding severe reactions and cautiously increasing the dosage. Three injections of 0.1, 0.2, 0.2 will frequently produce immunity, but the average adult may have the dosage increased, with an eye to the resultant reactions, and be given 0.1, 0.25, 0.5, and a final dose of 1 cubic centimeter, with the production of a high degree of immunity and no severe reaction.

Diphtheria immunization should routinely be done near the end of the first year of infancy, and should not be deferred until first school attendance. In infancy the immunity response is excellent and is better maintained; reactions are slight or nil, and protection is thereby secured through the early years of life when the hazard of the infection is greatest.

Schick Test. The Schick test is performed by injecting 0.1 cubic centimeter of a ready diluted toxin in peptone buffer intradermally into the skin of the forearm. The test is read in forty-eight to seventy-two hours; an area of redness greater than 0.5 centimeter in diameter denotes susceptibility. In small children, pseudoreactions are encountered very infrequently.

Diphtheria immunity is a relative, and not a "solid" immunity; but the universal performance of immunization affords tremendous protection against diphtheria.

II. PROCEDURES WHICH SHOULD BE DONE FOR SPECIAL INDICATIONS

1. *Typhoid Vaccination.* The injection of typhoid vaccine, in the usual series of three doses of the available vaccine, produces an active immunity which is fairly reliable for one to three years. The

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* Report submitted by Special Committee to the Pediatric Section of the California Medical Association at the sixty-seventh annual session, Pasadena, May 9–12, 1938.

dosage need not be much reduced for small children, and reactions in the young are minimal. In the average urban community public health safeguards afford sufficient protection against typhoid. Immunization should be practiced in any community in which the hazard of typhoid exists, or among those entering such a district.

It is impossible to make any test of the immunity conferred against typhoid.

2. *Whooping Cough.* There is evidence that some degree of protection is conferred against whooping cough by the injection of properly prepared Phase I vaccine. The degree, duration, and potential value of this method have not as yet been definitely demonstrated, and the occurrence of known occasional failures indicates the necessity for a critical point of view, and renders it unfair and unwise to promise too much to the parents regarding the immunity produced. Immunization, in order to be useful, must be given early in life, may be begun as early as the third month of life, and, if used as a routine, should not be deferred later than the fifth to seventh month, so that protection may be secured during the time of greatest hazard. There are several preparations of whooping cough vaccine which may be used, but injections should be given at weekly intervals with the administration of a total dosage of 80 to 100 billion organisms.

3. *Scarlet Fever.* Opinion varies regarding the precise value of this immunization. Reactions to the injections are sometimes unpleasant and the necessity for five doses is disadvantageous. The procedure is somewhat more unpleasant, and somewhat less effective, than diphtheria immunization, and the degree and duration of immunity are less certain.

Susceptibility to scarlet fever is in general indicated by a positive Dick reaction. This test is performed by the intradermal injection of 0.1 cubic centimeter of Dick test toxin, prepared for this purpose; an area of redness of 0.5 centimeter or larger at the end of twenty-four hours indicates susceptibility. After immunization, the presence of a negative Dick test should always be ascertained.

The immunizing dosage consists of five weekly doses of scarlet fever toxin, prepared for this purpose and consisting of 500, 800, 2,000, 8,000, 80,000 units.

The committee feels that scarlet immunization should especially be used for the protection of nurses and attendants in hospitals, or for other conditions where unusual hazard of infection exists. It does not recommend that scarlet immunization be generally employed as a public health or school health procedure, or used routinely in private practice.

4. *Tetanus.* A degree of immunity against tetanus is produced by the injection of 0.5, 1, and 1 cubic centimeter of tetanus toxoid at weekly intervals. This is not recommended as a routine procedure, but only under special conditions of exposure. This method should not be instituted under conditions which call for the prophylactic use of tetanus antitoxin.

5. *Rabies.* Active immunization should be attempted only following known or suspicious exposure by dog bite. Either Semple or Cummings vaccine may be used in fourteen or twenty-one doses, but in all suspicious bites about the head and face, or in young children, twenty-one injections should invariably be employed. One per cent procain or novocain, intradermally and subcutaneously at the site of injection, does much to reduce the resultant discomfort.

It is important to mention that cauterization with fuming nitric acid is by far the most effective agent which can be used in addition to active immunization.

III. METHODS WHICH SHOULD NOT BE EMPLOYED

The committee is of the opinion that methods proposed for the production of active immunity against poliomyelitis and tuberculosis contain potential dangers and experimental pitfalls which contraindicate their routine use in private practice.

IV. ADDITIONAL COMMENTS

The committee considers there is no proven agent for the production of active immunity against epidemic encephalitis, erysipelas, epidemic meningitis, epidemic parotitis, pneumonia, measles, or varicella.

The precise utility of respiratory vaccine for the prevention of the common cold, recurrent sinus and upper respiratory infections defies precise scientific definition. The immune response which follows the injection of respiratory vaccine cannot be demonstrated in the test tube, and has not conclusively been proved by controlled clinical experiments. The use of this vaccine is widely, and at least harmlessly, employed, and by men of unquestioned scientific attainments. The committee feels that the demonstrable utility is likely to be limited to the treatment of the allergic individual whose "colds" are on an allergic background.

CONCLUSIONS

There are a limited number of things which should be done to the average well child. Only those things which are unfailingly useful, safe, and effective should be advocated routinely. Those whose status is less conclusively proven should not be employed without their limitations being carefully explained. Most "immunization campaigns" undesirably emphasize the performance of immunization at school age. The importance of smallpox and diphtheria immunization in infancy should constantly be emphasized, and if anything is to be accomplished by whooping-cough immunization this should also be done in early infancy.

Your committee has made free use of a similar report recently issued by a committee of the American Academy of Pediatrics.

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BLIND LAWS OF CALIFORNIA: SOME COMMENTS*

By John P. Lordan, M.D.
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In the State of California, during the year 1937, $2,309,726 was spent on aid to the needy blind. About one-third was furnished by the Federal Government through its Social Security Act, one-third provided by the State of California, and the remaining one-third by the counties.

In December, 1937, the State Social Welfare Board appointed an Advisory Committee of Ophthalmologists. Dr. Percival Dolman (chairman), Dr. Joseph McCool, and Dr. Joseph William Crawford made up the committee in Northern California, while Dr. George H. Kress (chairman), Dr. A. Ray Irvine, and Dr. John P. Lordan were the members for Southern California.

These two boards have met separately and in joint conference and have considered some of the problems confronting the State Social Welfare Board, Division of the Blind. Of paramount importance is the selection of a state ophthalmologist to work with the Blind Division on the advice of the consulting committees. At the time of this annual session this matter is still pending before the Social Welfare Board.†

COMMITTEE'S REVISED REPORT CARD ON BLIND APPLICANTS

Everyone has realized that the physician's report blank on blindness in use up to the present was unsatisfactory. This was taken up by the committees, the result being that a new form is now available. The confusion resulting from the placing of the left eye column before the right eye has been eliminated. There has been more room for the description of the findings made at the examination. A most important addition has been made to the bottom of the physician's report regarding the Social Security Board's instructions in determining blindness. The visual acuity is plainly stated, along with the amount of peripheral field contraction, to qualify the applicant as blind. It is probably well to emphasize here that all the physician is now asked to certify is "that he is a duly licensed practicing physician, skilled in treating diseases of the eyes, and that the applicant comes within the classification of blindness as stated at the bottom of the physician's report." In the event that a case is certified as blind by a physician, even though the degree of blindness stated is clearly not within the classification, such a case will not be reimbursed by the Social Security Board. This will leave the burden of care entirely upon the state and county.

EXAMINATION FEES

Where the applicant for blind aid desires to challenge the examining doctor's report that he is not blind, the Social Welfare Department is handling such individuals as they are now handled by the State Compensation Insurance Fund, *i. e.*, the second examination is paid for by the applicant, and the third by the state, the recommendations being made on the basis of the two agreeing reports.

Physicians' fees for examination are past due and unpaid owing to the influx of applications and renewals from all the counties. At this writing, a total of $3,601.50 has been paid by the Comptroller, indicating 720 examinations at $5 each. Two hundred seventy-one more invoices are pending in the Comptroller's office; two hundred more have been signed and in about a month the checks will be issued.

The Social Security Board requires that certain social data be obtained regarding all cases open or closed for aid to the blind. The following tables have been compiled from the more elaborate federal form. These tables give some indication of the type of information available.

ANALYSIS OF TABULAR DATA

Table 1.—Individuals receiving aid to the blind in California from August, 1929, to February,

Table 1.—*Individuals Receiving Aid to the Blind in California August, 1929, to February, 1938, by Months*

	Year									
Month	1929	1930	1931	1932	1933	1934	1935	1936	1937	1938
January		491	1,076	1,472	1,996	2,296	3,216	3,936	4,542	5,324
February		630	1,109	1,495	2,034	2,356	3,262	3,998	4,575	5,451
March		781	1,148	1,560	2,079	2,434	3,334	4,032	4,640	
April		790	1,183	1,599	2,137	2,558	3,463	4,030	4,660	
May		802	1,209	1,608	2,159	2,670	3,526	4,129	4,701	
June		851	1,235	1,710	2,175	2,748	3,552	4,196	4,761	
July		894	1,266	1,747	2,207	2,766	3,621	4,271	4,795	
August	209	920	1,265	1,826	2,203	2,863	3,644	4,287	4,810	
September	235	1,003	1,317	1,841	2,217	2,868	3,727	4,366	4,892	
October	261	1,017	1,348	1,867	2,247	2,959	3,757	4,417	4,962	
November	300	1,032	1,366	1,938	2,244	3,084	3,861	4,441	5,100	
December	366	1,054	1,427	1,978	2,278	3,179	3,912	4,516	5,233	

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* Read before the Eye, Ear, Nose and Throat Section of the California Medical Association at the sixty-seventh annual session, Pasadena, May 9–12, 1938.

† A part-time state ophthalmologist was appointed in the month of June, 1938.

TABLE 2.—*Cost of Aid to the Blind in California*

	Total	Federal Funds	State Funds	County Funds
Actual expenditures for aid before federal funds became available; August 14, 1929, through June 30, 1936 (almost seven years)	$6.409,364		$3,204,682	$3,204,682
Actual expenditures from time federal funds were first received through the last fiscal year; July 1, 1936, through December 31, 1937 (one and one-half years)	$3,223,655	$1,191,345	$1,016,156	$1,016,154
Two and one-quarter million a year; increase two and one-quarter times in past one and one-half years since federal funds became available.				
Estimated expenditures for next five years under present laws	$17.280,000	$5,363,712	$5,958,144	$5,958,144
Estimated expenditures for next five years if federal funds are withdrawn	$17,280,000		$8,640,000	$8,640,000

1938, by months. You will notice that the cases have increased at the rate of about five hundred a year until there were, in February, 1938, 5,451 individuals receiving aid.

TABLE 3.—*Report for Month of November, 1937*

	Individuals	Amount	Average
State of California	5,100	$245,117.84	$48.06
Los Angeles County	2,572	$124,164.47	$48.28

Table 2 reveals that the cost of aid in the seven years prior to federal participation averaged about a million dollars a year, which was borne by the state and county funds. Since federal participation, the amount has increased to two and one-quarter million a year, or an increase of two and one-quarter times what it had been in the past. The estimated expenditures for the next five years under the present laws are $17,280,000.

TABLE 4.—*Aid to Blind: For Certain States*

California is second in total number receiving aid with 5,100.
Pennsylvania first with 10,932.
Ohio third with 3,747.
California is second in total payments with $245,118.
Pennsylvania first with $327,081.
Ohio third with $69,185.
California is first in average amount paid of $48.06.
Washington second with $34.46.
Wyoming third with $30.34.

Table 3 shows that over half the blind in the State of California are living in Los Angeles County, and that the monthly expenses run about $125,000, or $48.25 per person per month.

Table 4—One might well ask what is California's position with relation to other states, with plans approved by the Social Security Board. As of November, 1937, the data incorporated in Table 4 reveals some interesting contrasts.

TABLE 6.—*Individuals Accepted for Aid to the Blind: Classified by Age*

Age Groupings	Number	Per Cent
Total	1,534	100.0
16 and under 18	9	0.6
18 and under 25	50	3.2
25 and under 45	228	14.9
45 and under 60	363	23.7
60 and under 65—81 per cent	194	12.6
65 and over	690	45.0

The average grant for thirty-seven states was $25.58. Arkansas was lowest with $9.08, and Alabama second with $10.10. Only Maine and Pennsylvania are ahead of California in the number of recipients per 100,000 population.

Table 5 lists the expenditures for public assistance for the year 1937, the blind aid being the least in amount of the various types of public assistance. However, considering the limited number of individuals on blind aid as compared, for instance, with

TABLE 5.—*Expenditures for Public Assistance in California, January 1, 1937, to December 31, 1937*

	Total	Federal	State	County
Total	$148,807,279	$97,589,022	$31,513,438	$19,704,819
Works Progress Administration	81,834,000	81,834,000		
Old-age assistance	30,859,524	13,766,166	8,546,679	8,546,679
State Relief Administration	19,853,227		19,853,227	
County indigent aid	9,222,871			9,222,871
Children's aid	4,727,931	1,157,148	2,374,523	1,196,260
Blind aid	2,309,726	831,708	739,009	739,009

TABLE 7.—*Individuals Accepted for Aid to the Blind During Period November 1, 1936, Through June 30, 1937. Classified by Living Arrangements*

	Number	Per Cent
Total	964	100.0
Alone	168	17.4
In household group with relatives	624	64.7
In household group not with relatives	80	8.3
In voluntary institution, incorporated not for profit	24	2.5
In boarding home or lodging house	39	4.1
Other arrangement	26	2.7
Unknown	3	0.3

the county indigent, it is obvious that the blind aid is relatively high per person.

OTHER FACTUAL DATA CONCERNING BLINDNESS

Tables 6 to 11 elicit some interesting facts concerning the individuals receiving blind aid. It is shown that 81 per cent are over forty-five years of age, with more than half of them over sixty years.

TABLE 8.— *Individuals Accepted for Aid to the Blind During Period November 1, 1936, Through June 30, 1937. Classified by Number of Types and Other Assistance Received Simultaneously With Aid to the Blind in Households Having at Least One Person Accepted for Aid to the Blind.*

	Number	Per Cent
Total	964	100.0
No other type of public assistance	710	73.7
One additional type of public assistance	248	25.7
Aid to dependent children	18	1.8
Old-age assistance	54	5.6
Other public assistance (county, SRA, etc.)	176	18.3
Two additional types of public assistance	6	0.6
Aid to dependent children and other public assistance	5	0.5
Two types of other public assistance	1	0.1

The information given in Table 7 is further borne out when we see, in Table 8, that three-fourths of these households are receiving no other type of public assistance other than blind aid.

TABLE 9.—*Individuals Accepted for Aid to the Blind During the Period November 1, 1936, Through June 30, 1937. Classified by Race and Sex*

	Total		Male		Female	
	Number	Per Cent	Number	Per Cent	Number	Per Cent
All races	964	100.0	540	100.0	424	100.0
White	805	83.5	445	82.4	360	84.9
Negro	77	8.0	46	8.5	31	7.3
Other	82	8.5	49	9.1	33	7.8

Table 7 shows that two-thirds are living with relatives, who claim they are unable to provide for the blind one, and are more than likely deriving some support from him.

In *Table 9* is pointed out that 83 per cent of the cases were of the white race, and in the next that three-fourths are native and one-fourth foreign-born.

TABLE 10.—*Individuals Accepted for Aid to the Blind During Period November 1, 1936, Through June 30, 1937. Classified by Nativity and Race*

	All Races		White		Negro		Mexican		Other	
	Number	Per Cent	Number	Per Cent	Number	Per Cent	Number	Per Cent	Number	Per Cent
Total	964	100.0	805	100.0	77	100.0	42	100.0	40	100.0
Native-born	711	73.8	603	74.9	65	84.4	12	28.6	31	77.5
Foreign-born	238	24.7	193	24.0	11	14.3	27	64.3	7	17.5
Europe	159	16.5	148	18.4	11	14.3				
Asia	12	1.3	5	0.6					7	17.5
America (not United States)	64	6.6	37	4.6			27	64.3		
Other	3	0.3	3	0.4						
Unknown	15	1.5	9	1.1	1	1.3	3	7.1	2	5.0

Table 11.—*Native-Born Individuals Accepted for Aid to the Blind During the Period November 1, 1936, Through June 30, 1937. Classified by Section of Country.*

	Number	Per Cent
Total	711	100.0
New England	20	2.8
Middle Atlantic	68	9.5
East North Central—42 per cent	157	22.1
West North Central	138	19.4
South Atlantic	19	2.7
East South Central	39	5.5
West South Central	68	9.6
Mountain	37	5.2
Pacific	161	22.6
Washington or Oregon	32	4.5
California	129	18.1
Outlying possessions	4	0.6

From where the blind come to California is well indicated in Table 11. Forty-two per cent come from the east and west north central states, and there is the equally significant figure of only 18 per cent being native Californians.

Table 12 classifies the 25 per cent that are foreign-born, emphasizing that nearly half are aliens who represent about 12 per cent of the total receiving blind aid.

COMMENT

Statistics as to where the blindness was contracted are as yet not available. This certainly should be incorporated in the social history of the patient. It would then be possible to determine how much of the "blind load of the United States was being dumped into California."

There are no figures obtainable on causes of blindness in this state. This table represents the causes as ascertained by several thousand applicants for aid from 1922 to 1936, in Missouri, Illinois, and Pennsylvania. For comparison, the amount of blindness from the same diseases appearing in students in schools for blind children appears in the last column. Of especial interest is the high figure—about 20 per cent in each group—due to cataract. Whether of unoperated, or the end-results of unsuccessful surgery, is not stated. Glaucoma contributes about 10 per cent, and the amount of congenital hereditary blindness is striking. Trachoma as a cause of blindness in Missouri, while almost nonexistent as a cause in Pennsylvania, is most interesting.

Now that the Federal Government has begun its fight against syphilis, we can expect the 15 per cent of blindness due to this disease to be reduced. In considering prevention of blindness it is probably known to all that smallpox was the greatest single cause of blindness many years ago.

Table 12.—*Foreign-Born Individuals Accepted for Aid to the Blind During Period November 1, 1936, Through June 30, 1937, Classified by Citizenship and Sex*

	Total		Men		Women	
	Number	Per Cent	Number	Per Cent	Number	Per Cent
Total foreign born 24 per cent of all cases	247	100.0	144	100.0	103	100.0
Citizen	123	49.8	73	50.7	50	48.5
First papers	9	3.6	8	5.6	1	1.0
Alien	115	46.6	63	43.7	52	50.5

Twelve per cent of total cases on blind rolls are aliens.

Table 13.—*Causes of Blindness: Period 1922-1936*

	Illinois [1] Per Cent	Missouri [2] Per Cent	Pennsylvania [3] Per Cent	Children [4] Per Cent
Cataract	20.0	15.0	22.0	15
Glaucoma	8	10.4	13	.2
Trachoma	9	19.7	.54	.5
Congenital and hereditary	2.3	1.4	4.5	50
Ophthalmia neonatorum	3	2.3	4	10
Trauma	11	2.4	14.6	8
Optic atrophy	15	13.7	10	14

[1] Illinois—3,517 blind pensioners.

[2] Missouri—7,126 blind eyes.

[3] Pennsylvania—11,852 blind eyes.

[4] Children—2,702 children.

TABLE 14.—*Cases Closed for Aid to the Blind During the Period November 1, 1936, Through June 30, 1937, Classified by Reason, for Closing Case.*

	Number	Per Cent
Total	564	100.0
Death largest cause for closing case	292	51.8
Vision wholly or partially restored	6	1.1
Admitted to public institution	58	10.3
Became self-supporting for reasons other than restoration of sight	30	5.3
Relatives became able to support	46	8.1
Moved out of district	37	6.6
Not eligible for original grant	74	13.1
Other reason	21	3.7

HOW CASES ARE "CLOSED"

Table 14 gives the reason for closing cases. It is instantly obvious that the only way that over half the cases can be removed from the blind rolls is by the death of the recipient. Two other classifications, one not originally being eligible for the grant in 13 per cent, the other having vision restored in one per cent, afford other possible means of closing cases. The Social Security Board feels that about 10 per cent could be closed if surgery were mandatory where it is clearly indicated. This is already the law in the states of Oregon and Washington.

COMMENT

Oregon, with thirty-six counties, has 405 needy blind receiving an average of $25.03 a month.

Oregon has thirty-six counties. Capital, Salem.

Four hundred and five blind persons were receiving assistance as of June 30, 1937.

Average amount of aid, $25.03.

Maximum amount of aid allowable per month. $30.

This state has an Advisory Board of three ophthalmologists.

HISTORY OF CALIFORNIA LAWS FOR BLIND

The law granting state and county aid to the needy blind in California was enacted by the Legislature in 1929. Prior to the enactment of this legislation the needy blind were granted $15 a month by the counties. Amendments to the law were enacted in the regular legislative sessions of 1931, 1935, 1937, and the extraordinary session of 1936. The aid is administered in California by the counties under the direction and supervision of the State Department of Social Welfare. Provision for this supervision was included with legislation enacted in 1929. Since July 1, 1936, the Federal Government has been participating in aid to the blind in California under the Social Security Act by a grant of one-half of whatever amount of aid is allowed, up to $30 a month. Amendments passed in the legislative session of 1937 have liberalized the provision for the state's needy blind.

At present the amount of aid the individual can receive is $50 a month, with the privilege of increasing this to $83.33 per month from other sources, *i. e.*, income from real and personal property owned by applicant, gifts, or applicant's own labor. A wife living separate from her spouse may receive separate aid to the same amount, or a maximum aid possible for the two of $166.66 per month.

In conclusion, the members of the Advisory Committees hope that these comments on the needy blind and the blind aid law will make all ophthalmologists, all doctors of medicine, and all citizens of the State of California, more familiar with this worthy cause in which we are all so vitally interested. It is our wish that you register your opinions before your local medical societies, and that out of your discussions may come helpful suggestions in this problem.

2007 Wilshire Boulevard.

A PLEA FOR CONSERVATIVE OBSTETRICS *

By ABRAHAM BERNSTEIN, M.D.
San Francisco

DISCUSSION *by Robert D. Dunn, M.D., Palo Alto.*

STATISTICS show that of every two hundred women who become pregnant, at least one dies. Seven per cent of the deaths of women between the ages of twenty and forty years are due to puerperal infection. Conservatively estimated, twenty-three thousand women die every year in the United States from the immediate and remote effects of childbirth. Tuberculosis is first, childbirth is second, in the number of deaths in women from fifteen to forty years of age. One hundred thousand babies die every year in the United States during delivery, and another one hundred thousand die in the first four weeks thereafter. This is three times as many men's lives as were lost in the World War, and these mothers' and babies' deaths were from causes largely due to the process of childbirth itself, and largely preventable.

What are the causes of these evils? The standard of obstetric practice is low. People are allowed to believe that labor is a natural process and requires no special care. Therefore, men with the best minds and with the greatest skill find their endeavors better rewarded in other specialties of medicine.

The Scandinavian countries show a 4 per cent operative obstetrics against our 10 to 30 per cent. Sweden, Norway, Denmark, and Holland have the lowest rate. Scotland's mortality is as high as that of the United States.

MATERNAL MORTALITY RATE

	Per 10,000 Live Births
Sweden	27
Scotland	59
United States	67
Italy	26
Japan	35

There is no question that better conservation of mother's strength during labor and better trained obstetricians would result in fewer indications for forceps, and consequently we would have less sepsis, hemorrhage and shock, and, naturally, better results.

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* From the Department of Obstetrics and Gynecology, Franklin Hospital, and the University of California Medical School.

For the past decade the infant mortality rate in San Francisco has steadily declined. Doctor Geiger showed that, in 1934, the rate dropped to an all-low of thirty-three per one thousand live births; in 1935, rose to thirty-five; and in 1936 to forty-two per one thousand. In San Francisco, as in other cities, the majority of infant deaths occur in the neonatal period.

CAUSES OF MATERNAL DEATHS

The causes of maternal deaths are criminal abortion, drugs used to bring on abortion, and high forceps, or even low forceps. Cesarean section also takes its toll, especially when done after the patient is infected or has been in labor a long time. In potentially infected cases, where a patient has been examined vaginally and forceps attempted with poor results, the Latzko or extraperitoneal cesarean section should be performed; this would decrease our mortality rate for cesarean section to some extent.

FORCEPS DELIVERIES

As far as forceps delivery is concerned, the advantages occurring largely benefit the mother, since there is little acceptable evidence that instrumentation is advantageous to the child. I make this statement despite the fact that three-fourths of all forceps deliveries are undertaken because of so-called fetal distress, as indicated by variations in the rate and rhythm of the fetal heart tones. On the assumption that compression of the head and congestion of the cerebral vessels produce the fetal cardiac variations, the birth of a live child after further compression by forceps would seem to constitute *prima facie* evidence that the hurried delivery was not necessary; as a matter of fact, failure to utilize this excuse for the application of instruments does not disturb the fetal mortality rate. Moreover, there is no good reason to believe that forceps delivery in the course of a slow labor diminishes the risk to the child, in spite of numerous recent warnings that the infant's head may be injured by pounding against the pelvic floor.

Rapid birth, whether preceding naturally or developed artificially by the injudicious use of pituitrin, is far more dangerous to the child, because of the increased likelihood of intracranial hemorrhage. However, there are rare conditions which arise, such as prolapsed cord with the head well down in the canal, in which rapid forceps extraction may be life-saving.

Excluding the large number of "convenience forceps" deliveries done under the name of prophylaxis to save the child or mother from varied and sundry difficulties, the generally recognized indications are eclampsia, placenta previa, heart decompensation, and abruptio placenta. There really is no place in obstetrics for the so-called "convenience forceps." Figures on both the immediate and late injuries to the child show beyond a doubt that the higher the station of the fetal head at the time of delivery the more damage is done. Novey, of the University of Maryland, reports 5 per cent forceps deliveries in a series of 16,442 cases covering a ten-year period and delivered on the clinic service. The number of forceps deliveries was one in twenty-nine. The total mortality was 1.76 per cent and the corrected infant mortality was 9.4 per cent. From the figures which Novey presents, one can with assurance draw the conclusion that forceps is a dangerous instrument and should only be used upon suitable indications, and only by one skilled in its application.

Plass, in his report in 40,143 births in Iowa, shows a forceps incidence of 7.1 per cent. In the hospital deliveries, the forceps incidence was 13.8 per cent, while in the home the incidence was 4.5 per cent.

The lower operative incidence in home practice was associated with a stillbirth rate 2.45 per cent lower than that obtained in the hospital, 3.61 per cent.

At the Franklin Hospital, in a series of 2,608 deliveries, there was a forceps incidence of 14.6 per cent and a fetal mortality rate of 2.2 per cent.

In the late Doctor Breitstein's practice, in 8,850 deliveries there was a forceps incidence of 12.8 per cent and a fetal mortality of 3.8 per cent.

In my own practice, up to the present time, I have a forceps incidence of 14 per cent and a fetal mortality of 2.5 per cent.

Difficulties in forceps delivery usually appear because the physician has not demanded fulfillment of the classic conditions for the safe application of instruments, namely, that the cervix must be fully dilated or easily dilatable; there must be no disproportion between the head and the pelvis; position of the head must be accurately known so that the blades may be applied in the biparietal diameter and rotation effected in the proper direction, and the bag of water must be ruptured.

The application of forceps through a partially dilated cervix is dangerous, because further dilatation under such circumstances is often accomplished at the expense of lacerations, which may extend up into the lower uterine segment and cause severe bleeding.

Manual dilatation or radial incisions, according to the technique of Duhrssen, offers a more satisfactory solution when immediate delivery is necessary for a cervix that is not fully dilated.

The danger to fetus and mother in forceps delivery depends largely on the indication under which the procedure is undertaken. It also depends on the skill of the operator, but especially on the station of the head. Obviously, there is less danger on a low or perineal forceps than on a mid- or high-forceps delivery.

Cervical lacerations occur with forceps deliveries many times, and immediate repair of such cervical tears has considerable support in many clinics.

CONCLUSION

In conclusion, I wish to emphasize that women are no different today than they were a thousand years ago. They should be given every chance in the world to have their babies naturally. More conservative obstetrics, and less hurry, will certainly give us better results and help decrease our high maternal mortality rate.

350 Post Street.

DISCUSSION

Robert D. Dunn, M. D. (300 Hamilton Avenue, Palo Alto).—There is no doubt that the high fetal and maternal morbidity and mortality in this country are due in part to untimely interference by the obstetrician. This morbidity and mortality usually occur when interference is attempted with the head at too high a station and the cervix not fully dilated. If patience could be the watchword when the fetal heart shows no embarrassment to the child and the maternal pulse indicates no deleterious effect on the mother, labor would often advance surprisingly normally. This patience, of course, is difficult to practice even in moderately long labors, when one has the family of the patient constantly demanding that the doctor "do something."

In modern obstetrics this situation is most easily handled by the use of analgesia. The patients under influence of medication do not suffer, and thus permit more prolonged labor. This added time will decrease the incidence of mid-forceps considerably, but will increase the use of outlet forceps. The latter, however, in trained hands, cannot be considered a factor in increasing either maternal or fetal mortality.

High forceps should have no place in modern obstetrics. Although the mortality of cesarean section is high, that of high forceps is greater. If a patient is infected, with the head still not engaged, either a Latzko extraperitoneal cesarean section or a uterine marsupialization is safer than a high forceps procedure.

Conservatism does not imply a strictly *laissez faire* policy. It is most essential that the actual condition of the case at hand be understood. Then, if necessary, skillful and timely intervention is just as much a part of conservative treatment as the nonoperative approach to normally advancing cases.

If the author's plea for conservative obstetrics is to be effective, it is important for us to teach our medical students that interference in an obstetrical case is as serious as undertaking a major surgical operation. Thus, it should be attempted only after careful consideration, and if there is any question as to the advisability of such a procedure, consultation is often a help and always a protection.

THE LURE OF MEDICAL HISTORY†

TRUTH OVERTAKES "DOCTOR HUNTER"

By A. W. Meyer, M.D.
Stanford University

PART I

"Whatever the truth may be, it is best that we should know it; and for truth of any kind we should keep our heads and hearts as cool as we can." Thus wisely counseled James Anthony Froude, in his admirable essay on the science of history. Since the two great Scotsmen, John and William Hunter, have been dead so long, it should not be difficult for anyone to keep his head and heart cool, with respect to the controversy between them. And, as for the truth in the matter, it has been available though apparently unrevealed ever since 1762. It is found in the apparently forgotten though crucial words of William himself. Although we had tried to learn the facts regarding the bitter controversy, this damaging footnote was not mentioned in the biographies, essays, addresses, Hunterian lectures and orations consulted. And, although Paget severely characterized the *Medical Commentaries* which contain it, and discussed the well-known estrangement, this footnote apparently had no special significance for him.

AUTHOR'S FORMER REFERENCES

In a footnote to Essays on the History of Embryology,[1] I incidentally expressed sympathy with John in his quarrel with William. I felt prompted to do so after carefully reading John's contribution, of 1780, to the Royal Society of London, entitled "On the Structure of the Placenta," and pondering the letters written by these gifted men regarding it. A few years later, when considering the work of John in embryology, I further stated:

> It is difficult to contemplate the splendid royal folio on the gravid uterus[2] by William without sympathy for John. It does not seem possible that the latter could have said what he did, and taken the steps he did more than a generation afterward, if he himself had not made the discovery he claimed, regarding the uteroplacental circulation; and surely nothing could be more evasive than the rejoinder of William. John was very specific and said that William received his conclusion with raillery at the time.[3]

When discussing the contributions to embryology of the Hunters, I reverted to the subject, adding:

> It may have been fortunate that John was probably unaware of the views of "eminent anatomists" referred to by Haller on this matter, unless he could also have known what Aranzi and others had thought, and what Falconnet and others [especially Monro, Sr.] had done, in order to solve the vexed problem of the uteroplacental circulation. Concerning the controversy between the two, Teacher regarded the account of William more probable than that of John. [However], one cannot contemplate the rejoinder of William to John, made to the Royal Society on February 3, 1780, without noting its evasion and ambiguity. It must be wholly unconvincing except to those to whom the possession of stolen goods is conclusive proof of their rightful ownership, for that is a form of reasoning resorted to by William. Moreover, one cannot help wondering what experience William had that caused him to declare to his students that ". . . most philosophers, most great men, most anatomists, and most other men of eminence lie like the devil." . . . it is well to recall William's words regarding the fetal and maternal portions of the decidua as quoted by Teacher (p. lvi), which are to the effect that the vessels of these two parts are separate because "those of the umbilical always 'remained uninjected.' 'It was this appearance,' he says (in his lectures of 1775), 'in the cat and bitch that first led me into the apprehension that the human placenta was the same. I thought this for a long time, but I never cared to assert it openly till within these few years.' "[4]

COMMENT

Since John claimed that he discovered the independence of the uteroplacental circulations in 1754, the last sentence in the above quotation alone would seem sufficient to dispose of William's claim. But, had he really thought so "a long time," that is, before 1754?

This [1755] was within a year of the time when he [John] had the exceptional opportunity to study and dissect a human uterus with fetus near term, injected by McKenzie, and the occasion on which John apparently rediscovered the independence of the maternal and fetal circulations. It seems that the cadaver had been injected through the uterine, and the unborn child through the umbilical vessels, and John said that he conceived the idea of the independence of the circulations while dissecting the placenta. Although he later wrote that his elder brother received the idea with "raillery," when he broached it to him at the time, it is a well-known fact that William maintained that it was his own discovery, and that he always had incorporated the idea in the first and only public lecture in the fall of every year. [But] had William sponsored the idea of the independence of the two circulations before 1754, it is extremely unlikely that John would have remained unaware of it, and he, hence, would have had no occasion to think that he had made a discovery when dissecting the female body injected by McKenzie, and so report to William. Moreover, according to Paget, the manuscript notes taken by one who attended William's lectures in 1755–1756 show "that William Hunter, even then, a year after the discovery of the placental structures, neither spoke of it nor understood the meaning of it"—the uteroplacental circulation. These words also are in complete accord with those quoted above from Teacher, and also [with] those from the anonymous auditor apparently written after the death of William, and, if true, fully confirm John's statement regarding William's reaction to the idea. Moreover, careful scrutiny of the text written by William himself for his famous folio, published in 1774, twenty years after John's rediscovery, confirms Paget's view completely, for the independence of the two circulations is only implied, not represented or asserted there.[5]

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† A Twenty-Five Years Ago column, made up of excerpts from the official journal of the California Medical Association of twenty-five years ago, is printed in each issue of California and Western Medicine. The column is one of the regular features of the Miscellany department, and its page number will be found on the front cover.

[1] California and West. Med., Vol. 36, No. 6, p. 394 (June), 1932.

[2] Hunter, William: Anatomia uteri gravidæ. Birmingham, 1774.

[3] California and West. Med., Vol. 43, No. 5, p. 362, col. 1, par. 2 (Nov.), 1935.

[4] California and West. Med., Vol. 46, No. 1, p. 38, par. 2 (Jan.), 1937.

When considering the controversy further, I wrote:

> ". . . it may be recalled that William said that his 'discovery' of the independence of the fetal and maternal circulations had been acknowledged by Haller thirteen or fourteen years before the disagreement with his brother John in 1780, in Haller's *Elementa physiologiæ corporis humani*,[6] Vol. 8, p. 220, which appeared in 1766. However, instead of having credited William with the discovery, Haller merely gave a brief summary of William's ideas in an addendum, retaining the contrary idea in the text and saying that Hunter's ideas regarding the decidua have been 'partly corrected and partly confirmed.' According to Haller's statement in this addendum, William believed that a liquid injected into the vessels of the uterus 'pours into every cellular part of the placenta, and from these cells returns into the broader veins of the uterus. None of it passes into the branches of the umbilical vessels. When the umbilical artery is filled with a colored liquid, while the placenta still adheres to the uterus, the branches of the umbilical arteries and veins are all completely and readily filled; yet nothing passes into the vessels of the uterus, unless the liquid has poured into the cells of the placenta.' Haller, hence, merely stated that William believed that the two circulations were independent without characterizing the idea as a discovery. Since this was written in connection with a historical summary of the idea, it is not without significance."

What is of special significance, however, is the fact that it was in this connection that Haller referred to page 52 of the *Medical Commentaries*[7] of 1762 where William stoutly maintained the opposite view.

OTHER COMMENT

Teacher (1900) concluded that ". . . it is unreasonable to suppose that they [the injections] were figured then [1750], yet only understood in 1754." (p. lvi.) But it seems equally strange that William should have remained silent in 1774 in regard to what he said, in 1780, he so firmly believed and thought he had discovered [before] 1754. I do not know upon what grounds Teacher (1899) stated that William's conclusion regarding the distinctness of the maternal and fetal circulations "was, as Hunter was aware, strictly speaking, not a new discovery" (p. 32), but if justified it robs William of his claim and reveals him in disparaging light. It may well be true, as Teacher held, that William Hunter presented the anatomical proof that the two circulations do not mingle, yet the real question is not whether he presented this proof, but whether he fully accepted it for man, before John, and that does not seem to have been the case. This point is referred to by an anonymous auditor of William's lectures, who recorded him as saying that

> These appearances I first saw in a cat that was pregnant, which I injected from the uterine vessels, after which I injected by the navel string. The injection was distinct; I afterwards saw the same in a bitch. These discoveries were early in life, and taught me to believe that the same course of things existed in the human species, though I could not demonstrate it, not having had an opportunity to inject a pregnant uterus; but soon after I did meet an opportunity, & the appearances staggered me. For after injection of the parts, I found the uterine injection filled up a great part of the placenta &c., which on examination proved to be spongy & cellular. (p. 82.)

Hunter no doubt was "staggered," as well he might have been, because the injections of pregnant human uteri, instead of being unequivocal as in the cat and dog, were confused and seemed to controvert the conclusion reached from injections of the carnivora mentioned. However, according to Needham, "His [William's] injections left no shadow of doubt about the matter, and the way was clearly opened up for the study of the properties of the capillary endothelial membranes separating the bloods . . ." (p. 201.)

Department of Anatomy.

(To be continued)

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[5] California and West. Med., Vol. 46, No. 1, p. 39, col. 2, par. 1 (Jan.), 1937.

[6] Von Haller, Albrecht: Elementa physiologiæ corporis humani, Vol. 8, p. 220.

[7] Hunter, William: Medical Commentaries. Part I. Containing a plain and direct answer to Professor Monro, Jr., interspersed with remarks on the structure, functions and diseases of several parts of the human body, VII, 113 pp. 4° London, A. Hamilton, 1762.

BUBONIC PLAGUE OUTBREAK IN SAN FRANCISCO—YEAR 1900[*]

THE first severe test of the competency of United States Public Health Service bacteriologists may be said to have occurred in 1900, when suspected cases of bubonic plague began to come to the attention of the local sanitary authorities in San Francisco. Dr. Joseph J. Kinyoun, formerly the director of the Hygienic Laboratory, was then assigned to quarantine duty at that port. It was his duty to be informed of local health conditions, and he obtained materials from some of these cases and reported that he had confirmed them bacteriologically as plague. The same confirmation followed at the Hygienic Laboratory on specimens which he sent there. There followed one of the most sordid and distressing stories of sanitary annals, lasting over many months, extending to the city and state governments, into local politics, the press, the agencies of the law, and even threatening international complications. It is within the power of a few microscopic plants on a glass slide, granted certain antecedents, to cause such upheavals in the affairs of man. The health agencies appear, from the record, to have come through the mêlée with at least honor unimpaired, but the political agencies and the press made but a poor showing in the cause of public service. Even the law, which we must not criticize, gave an example of how decisions arrived at, presumably in accordance with its rules and traditions, may protect undeserving persons and do the public an enormous disservice.

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[*] CALIFORNIA AND WESTERN MEDICINE, in the Lure of Medical History department (issues of November, 1938; December, 1938, and January, 1939), presented the story of the San Francisco Bubonic Plague outbreak in a series of articles by George H. Evans, M. D., who was president of the State Medical Association at the time. To supplement Doctor Evans' account, the comments of Medical Director A. M. Stimson of the United States Public Health Service, Washington, D. C., as recently given in Supplement 141 to the United States Public Health Reports, are given place in this February issue.

* * *

To shorten a long and unsavory story and get at the moral quickly, we shall simply give examples of what happened and not attempt a chronological account. The press presented a solid front not only in denying the existence of plague in San Francisco, but in belittling and hamperinng all those who entertained the opposite and true opinion. The City Fathers seconded and inspired the press in its efforts. The commercial powers, including the great Chinese Six Companies, resorted to almost all conceiveable tricks of intrigue, and even violence, to suppress knowledge of the true state of things. Doctor Kinyoun was alternately threatened and offered large bribes to recede from his position. Plots were made to destroy the patrol boats under his jurisdiction which attempted to prevent the smuggling of Chinese—well, sick, and dead—out of the city. The Navy had to be called in to give them protection. An injunction against sanitary interference in Chinatown was granted by a circuit judge. Doctor Kinyoun was cited in contempt of court on trumped-up charges. The Governor of the State accused the health authorities, local and federal, of incompetence and the use of illegal and unfair methods, and denied absolutely the existence of plague. And all this and much more because of the fear that if plague were publicly acknowledged, business prosperity would suffer. And what were the actual conditions? Some 25,000 Chinese lived in the section known as Chinatown. A few of them were wealthy and lived in sumptuous surroundings, but the majority lived under conditions which should never have been permitted on American soil, conditions of overcrowding, squalor, and degradation almost incredible to the eyes of the sanitary squads, when, after many months, they were finally permitted to go in and clean up. In this population, plague had doubtless been smoldering for weeks before the first case came to light; but with all the oriental arts of craft and ingenuity, the prying eyes of the health authorities were kept from seeing what was going on. Sick and dead Chinese were smuggled out of the city or otherwise disposed of so as to keep them from inspection. Persons sick for a day or two with buboes were represented as having been sick for a month with some chronic disease. This was the population which the press and the politicians, the law and business, arose in sanctimonious wrath to protect in its inalienable civil and legal rights. It was estimated that during the period of the injunction some one thousand Chinese left the city in one week, seeking refuge in the surrounding cities, villages, and countryside, from the pestilence which they recognized only too well. Does the chronic infection with plague among ground squirrels involving a large area in California, a constant menace and already the cause of many human deaths, date from this exodus?

* * *

As a final measure to meet this apparently hopeless situation, the Secretary of the Treasury, at the suggestion of the Surgeon-General, appointed a commission of impartial experts—Flexner, Novy, and Barker—to make an independent investigation. Although snubbed by the university where they sought laboratory space, and browbeaten by the Governor, they persisted, and in a short time brought in a verdict of plague (PHB 8, *1901*). Of thirteen deaths investigated, six were found bacteriologically to have been due to bubonic plague. After this, opposition smouldered and finally died out. The Public Health Service was asked to clean up Chinatown, and actually performed this herculean feat, and for the time San Francisco was free from plague.

Of course plague came back to San Francisco. The history of many a progressive and prosperous city, such, for example, as Liverpool, has shown that the infection, once established in the rat population, is difficult to eradicate. During the years, first of desolation and then of recuperation, cleaning up, and rebuilding which followed the San Francisco earthquake and fire of 1906, plague quite naturally reappeared with redoubled vigor. The wreckage of the buildings and sewers, the accumulation of vast amounts of rubbish, the flimsy construction of temporary abodes, the disorganization of food handling and garbage disposal, afforded ideal conditions for rat multiplication. It is instructive to reflect that under such conditions, and in the presence of an abundance of fleas, one old rat with chronic plague could start an epidemic.

* * *

At the time of the earlier epidemic, the Hygienic Laboratory was turning out large quantities of Haffkine prophylactic for use in the plague-threatened areas, this rather than the control of the rat population being considered at that time the chief reliance (AR *1900,* p. 676), and experiments were conducted to determine the viability of the bacillus on various objects (*ibid.,* p. 603).

* * *

During this epidemic a plague laboratory was set up by the Service in San Francisco, which, with the exception of about three years of quiescence, has been maintained in various quarters up to the present time. Here Currie, in 1903, described chronic plague in the rat, since recognized as an important factor in maintaining infection. In the following years, under the direction of McCoy, a great many studies pertaining to the disease were made, dealing with such subjects as the infectibility or resistance of various species of small animals, the pathology of rodents with plague, bacteriological methods, the rôle of various fleas, and the bionomics of rodents. In the latter connection it was found that when *Rattus norvegicus* had been significantly reduced in numbers by the campaign, the other varieties, *R. rattus* and *R. alexandrinus,* rapidly increased, introducing new factors in the control program because of their different habits (AR *1912,* p. 152). It seems unnecessary to refer to these contributions categorically. They were very useful to Service officers in following plague campaigns (New Orleans, Hawaii) and played their part in building up the present-day conception of the disease and its bacteriology. During the New Orleans campaign C. L. Williams showed that routine microscopic examination of rat spleens and livers reveals infection in some cases (35 per cent of total plague rats) not discoverable macroscopically (RPHR 357, *1916*). It is, perhaps, worth recording that in this outbreak, plague rats were not discovered until several thousands of them had been examined, showing how focal the infection may be in such cases. The remarkable retention of viability and virulence of nontransferred agar cultures of the plague organism (nine years) and of the organism in guinea-pig spleens in glycerin at minus 15 degrees Fahrenheit (seven years) is reported by Francis (RPHR 1535, *1931*).

* * *

The antiplague activities of the Public Health Service, in the absence of any recent human outbreaks, have now sifted down to three: Trying to keep shipping free from rats (C. L. Williams, RPHR 1267, *1929*) (Grubbs and Holsendorf, SPHR 93, *1931*), perennial supervision of the so-called plague-free zones around California cities, and the control of rural plague in Hawaii, where the disease is epizoötic in field rats and a new species of fleas, *Xenopsylla hawaiiensis,* appears to be the common transmitter (AR *1933,* p. 9) (Eskey, PHB 213, *1934*).

* * *

While other Pacific Coast cities, besides San Francisco, have been visited by plague, and there have even been small outbreaks of the pneumonic type, the human mortality has, fortunately, been small although rat infection has sometimes been considerable. The history of plague in Seattle has recently been written interestingly and completely by Fricks (PHB 232, *1936*).

* * *

Plague has possibly come to be regarded by Americans as an exotic disease of historic interest only, or at least confined to relatively undeveloped countries and populations. Probably few realize that the disease is firmly entrenched on our own territory, among the ground squirrel population of the far West, and that only by eternal vigilance has it been prevented from invading the rat populations of cities, and from them infecting human beings. While eradication may appear well-nigh impossible, more favorable conditions of attack have been afforded by some of the health provisions of the recent Social Security legislation. Mobile laboratories have been successfully used in locating foci of infection.

United States Public Health Service.

CLINICAL NOTES AND CASE REPORTS

TOXIC NECROSIS OF LIVER FOLLOWING USE OF SULFANILAMID*

By Paul Fitzgibbon, M.D.
and
Barney Silver, M.D.
Los Angeles

The literature on sulfanilamid is accumulating so rapidly that we are reluctant to contribute to it; but as far as we have been able to find out, there is as yet no fully described case in which toxic necrosis of the liver has been attributed to the use of this drug.

REPORT OF CASE

The patient was a 37-year-old white, a carpenter, whose medical history previous to his present illness was not remarkable. It included an attack of scarlet fever when he was 12, gonorrhea at 18, and abscesses of teeth and otitis media several years before admission. He also had attacks of numbness and tingling, together with blanching of his fingers during the winter months. These symptoms were relieved by immersing the hands in warm water. Whether these attacks were serious enough to merit the diagnosis of Raynaud's disease is probably unimportant to say. The family history does not seem interesting enough to relate.

He was well then until June 13, 1937, when he noticed a urethral discharge. A smear made at the Los Angeles City Venereal Clinic was positive for gonococci. The usual local treatment for eleven days was without effect, and on June 24, when he still had a frank discharge, and positive smear, as well as uniformly cloudy urine in the three-glass test, he was started on sulfanilamid. The dosage was eighty grains the first day, and the discharge lessened at once. On the third day, when he got sixty grains, the discharge was gone; but the drug was continued for nine days more, by which time he had taken, altogether, 500 grains of sulfanilamid. At this time he began to notice a little weakness and headache, and the drug was stopped. But a few days later, on July 11, he had a few shreds in the urine, and the drug was again started, on a dosage of forty grains a day. At the end of the fourth day the urine became a deep amber, and he developed a generalized maculopapular eruption; limited sharply to those areas which had been exposed to the sun, but sparing the face. He felt ill, had a fever of 101 degrees, but took some magnesium citrate and cascara on his own initiative, and in three days the complaints had entirely disappeared. The blood Wassermann and urethral smear were each negative at this time. The drug was, of course, stopped.

The patient was then followed in the clinic for some time; had a full-sized sound passed, together with silver nitrate instillation of the posterior urethra, and later a trial bout of alcohol and sexual intercourse, without showing anything more than a few shreds in the first glass. The shreds were persistently negative for gonococci.

Then, on the morning of August 25, six weeks after his last dose of sulfanilamid, he thought he saw a little tear at the meatus of his urethra. On his own volition and without seeking advice, he took fifteen grains of the same drug which had been given him at the clinic two months before. Within five hours he developed an urticarial rash, with intense itching and fever. On the third day, the rash had cleared somewhat, but he still felt very weak. Three days later, on September 30, he noticed he was becoming yellow, that his urine was becoming dark, and that his stools were a light gray.

He stayed at home, gradually becoming sicker, until, on September 17, he was finally admitted to the urological service at the Los Angeles County Hospital.

On the ward he was afebrile, had a severe jaundice and looked toxic, but he had no specific complaints. There was

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* From School of Medicine, University of Southern California.

Table 1.—*Laboratory Findings in Case Reported*

June 14, 1937—Smear positive G. C. Urine essentially normal except for pus. B. W. R. negative.

June 22, 1937—Smear negative G. C.

July 11, 1937—First rash. Urine deep slate color. Stool normal.

August 26, 1937—Second rash. Urine deep amber. Smear negative G. C.

September 3, 1937—Urine bile stain. Stool urobilin negative.

September 17, 1937—Urine deep bile stain. Icterus index 133. Van den Bergh direct prompt, indirect 9.4. Stool urobilin negative. CO_2 combining power 64, hemoglobin 13½ gms./100 c.c. R. b. c. 4.08 m. W. b. c. 8,250. Sulfhemoglobin negative. Methemoglobin negative.

September 25, 1937—Urine deep bile. Icterus index 135. Blood phosphatase 3.5. Hemoglobin 14 gms./100 c.c.

October 5, 1937—Urine deep bile. Icterus index 200. Van den Bergh direct prompt, indirect 12.3. Phosphatase 3.7. Hemoglobin 13.5. R. b. c. 4.6 m. W. b. c. 4,600. N. P. N. 18. Urea nitrogen 12. Blood cholesterol 166. Blood phosphorous 3.09.

October 8, 1937—Urine deep bile. Stool beginning urobilin positive. N. P. N. 26. Urea nitrogen 8.

October 12, 1937—Urine deep bile. Icterus index 200. Van den Bergh direct prompt, indirect 9.6. Stool urobilin positive. N. P. N. 75. Urea nitrogen 50. Creatinin 3.1.

October 18, 1937—N. P. N. 54. Urea nitrogen 25. Amino acid blood 6.6/100 c.c. Blood sugar 155. E. K. G. Sinus bradycardia and myocardial impairment. Urine amino-acids 1.40 mg./24 hours.

October 19, 1937—Urine mild bile and icterus index 80. Van den Bergh prompt. Indirect 5.1. Stool positive urobilin. N. P. N. 33. Urea nitrogen 15.

no anemia; digestion was satisfactory and, while in bed, he was fairly comfortable. The liver was not palpable or tender.

He remained on the ward for a week essentially unchanged, when he stubbornly decided that he had to go back to work and left, against the advice of the staff. He remained on a high carbohydrate diet, but he did not get along well, and finally got so sick that he again applied for admission to the hospital where, on October 5, 1937, he arrived on the medical service of Dr. John C. Ruddock.

This time he was much more ill; the jaundice was deeper, he had a profound anorexia, and shortly began to vomit. He was still afebrile, and had no anemia. The liver was now felt three fingers below the costal margin, and moderately tender. The right diaphragm was markedly elevated by the hepatomegaly. As can be seen in the accompanying table, he rapidly developed the clinical and laboratory picture of an acute toxic necrosis of the liver. There was some leukopenia. The blood urea was reduced out of proportion to the total nonprotein nitrogen, while the amino-acid nitrogen was not found abnormally high. About one week after admission he was so sick that it seemed he would not recover. At this time he developed some urinary suppression, coinciding with the high nonprotein nitrogen retention noted in the table; but the next day he responded to repeated doses of concentrated intravenous glucose, and from that time on gradually began to improve. This improvement, once begun, proceeded rapidly, and he left the hospital on October 20, 1937, still slightly jaundiced but definitely convalescent.

Table 1 indicates the laboratory work which confirmed the diagnosis.

COMMENT

This, then, is the most alarming complication noted among some 712 patients who have been per-

Table 2.—*Incidence of Side Reactions in Two Hundred Consecutive Cases of Gonorrhea Using Sulfanilamid*

Symptom	Number of Points	Per Cent of Points	Comment
Weakness	72	36	Most frequent but of little significance
Dizziness	67	33	Same
Dyspnea	60	30	Only two cases had to be D. C. on this account
Headache	33	16.5	
Anorexia	32	16	
Drunk feeling	25	12.5	
Sleepiness	22	11	
General aching	19	9.5	
Nausea	19	9.5	
Cyanosis	19	9.5	Oxygen tent for one patient for twenty-four hours
Vomiting	9	4.5	
Fever	8	4	
Rash	11	6.5	About 50 per cent photosensitive
Constipation	6	3	
Diarrhea	2	1	
Paresthesia	4	2	
Cycloplegia—Temporary	0	.5	
Peripheral neuritis	0	0	One case known outside this series
Precordial pain	2	1	
Temporary deafness	2	.5	
D. C. drug due to S. R.	17	8.5	
Urticaria	1	.5	
Toxic necrosis liver	1	.5	One case reported above
Death	0	0	

sonally observed by one of us (B. S.) at the Los Angeles City Venereal Clinic since the use of sulfanilamid was begun there on May 12, 1937. It is not intended to comment on this experience at this time further than to show Table 2, which tells at a glance the variety and incidence of complications that may be expected from an extensive application of the drug.

It seems to us that the most significant feature of this record is the prompt development of jaundice in a patient who took a very small dose of a drug which he had taken in large amounts two months previously. This raises the question of sensitization to the drug in a susceptible patient; an issue which has become familiar in the literature on pyramidon, neoarsphenamin, sedormid, cincophen. The fact that this type of sensitization has not yet been already produced in animal experiments is disappointing to those who have advocated the allergic character of these certain types of drug hypersensitivity, but the possibility of an allergic mechanism is still unrefuted. We have made no studies in sensitization, experimentally or otherwise, with this drug, but we think it important to point out the striking similarity of this record to those which have been described in reports on the harmful effects of pyramidon, neoarsphenamin, etc. We think it is probably worth while to comment also on the fact that our patient exhibited frank signs of injury, *i. e.,* fever, rash, etc., from the original large doses of the drug. Whether this circumstance should be regarded as indicating that he was a likely candidate for the development of sensitization later, we are unable to say. But as a point of practical clinical management, we think it hazardous to assume otherwise, for the present at least, and we venture the suggestion that patients who have shown untoward effects from an initial administration of the drug should be especially guarded against its repetition when sensitization has had time to develop.

SUMMARY

A case of liver necrosis, following the use of sulfanilamid, is reported, and a brief tabulation of the complications of this drug in a series of two hundred cases has been appended.

1200 North State Street.
1712 N. Highland.

VITAMINS A, B_1, B_2 AND D: EFFECTS OF DAILY ADMINISTRATION OF CONCENTRATES*

By Florence G. Stone, B.A.
Mira S. Bird, B.A.
and
Hazel E. Field, Ph.D.
Los Angeles

CONSIDERABLE work has been done regarding the efficacy of specific vitamins upon definite diseases, and under carefully controlled conditions. Probably less has been done in observing the general effects of combinations of vitamins employed upon people under normal conditions. The health service of our institutions of higher learning seems to have an unusually good opportunity for such investigations, and accordingly twelve college students between eighteen and twenty-three years of age were carefully selected, during their fall medical examinations, for a test of vitamin therapy. Six men and six women were chosen, but because one of the women failed to coöperate she is not included in this report, except occasionally as in the nature of a control.

STUDENTS CHOSEN FOR THE STUDY

The students chosen were below normal physically and, therefore, presumably of the type most in need of additional vitamins. Nine of the eleven were underweight and undernourished; all were subject to frequent colds, which is a chief cause of trouble for the college student; four had chronic sinus infections; five were subject to influenza; one to pneumonia; and one had had tuberculosis. Two students were subject to hay fever. Acne was present in six students, and dry skin, nails, and hair in one. Five students complained of frequent headaches, and many of them tired easily, both mentally and physically, after less than the normal amount of work. All of these were carrying a full program of college work, and all but two were working outside at various odd jobs, spending in remunerative employment from eight to fifty hours a week, or an average of about nineteen hours. They were found to vary in the amount of sleep they obtained: three averaging about six hours, one seven hours, five eight hours, and two nine hours. It was impossible to control the food taken, but all were eating in the college dining hall and, therefore, under somewhat the same conditions.

These students were then given three capsules daily of a concentrate of vitamins A, B_1, B_2, and D, beginning the middle of November, 1936, and continuing to about the first of March, 1937; and each was checked every two or three weeks, by personal interview, as to any change in conditions, especially weight, appetite, resistance to disease, muscular and mental fatigue, cutaneous conditions, headaches, eyes, and the general sense of well-being. They were also observed for about four weeks after the discontinuance of the vitamin therapy.

Possibly the most noticeable result was the marked decrease in the number of respiratory infections to which the group was by selection predisposed. Three of the students had no colds at all, two had only a slight sore throat, three had slight colds, two had colds of average severity, and only one continued to have colds throughout the winter. This is an excellent record, when we recall that all of these normally had many colds. During the winter there was a considerable influenza epidemic in the area, but in spite of this fact, only one student was mildly affected. In the four cases of sinus difficulty, two were completely cleared of it, and the others were considerably improved. In this connection it might be mentioned that the students having hay fever showed decided improvement, but no study was made of the offending substance supposedly the cause.

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* From the Health Service and the Department of Biology of Occidental College, Los Angeles.

The A, B, D capsules from the Abbott Laboratories were kindly furnished by them for this experiment.

Table 1.—*Effect of Ingestion of Vitamins A, B_1, B_2, and D on Respiratory Infections of Persons Habitually subject to colds.*

Case	Colds		Influenza		Sinus Infection	
	During	After	Before	During	Before	During
R. B.	One light	0	0	0	0	0
B. A.	0	One average	0	One light	Chronic	0
P. H.	Laryngitis*	One average	0	0	0	0
P. B.	One average	0	Subject to	0	0	0
G. C.	0	One average	0	0	0	0
E. F.	One average*	One severe	Subject to	0	0	0
D. D.	3	0	0	0	Chronic	Improved
J. S.	Many	0	Subject to	0	0	0
C. B.	0	0	Subject to	0	0	0
F. G. S.	One light	One average	0	0	Chronic	0
F. S.	One light	0	Subject to	0	Chronic	Improved

* Contracted when neglected to take capsules for one to two weeks.

LATER OBSERVATIONS

After the discontinuance of the vitamin therapy, enough of the previous conditions recurred to indicate that this type of subject was usually not capable of appreciable vitamin storage. From one to three weeks after the administration of the concentrate, five of the group contracted a cold, two developed laryngitis, one had a return of sinusitis, and a fourth a severe case of bronchitis. This latter case of bronchitis was that of a young man in the group, who was working very hard, getting only six hours of sleep. Three students noted a loss of energy when no longer receiving the capsules, but only one of these was in the group having colds. The four remaining students noticed no change in their health, and presumably were able to store the vitamins for at least the period of observation.

It was found that all of the eleven subjects gained in weight during the time of administration of the capsules, but the other student who did not take the vitamins failed to gain. Three gained as much as ten pounds or over. Five of the subjects had an increase in appetite, and those reporting a better appetite were the ones who made the greatest gains in weight. Three students thought they had less appetite at first, until they were accustomed to the capsules.

Less susceptibility to fatigue and a better general sense of well-being were quite noticeable. All of them reported that they felt in better health. Eight of them stated that they did not tire as quickly at physical work as before, while five students believed they were more alert mentally and better able to study.

Several other improvements were noted to varying degrees. Six of the students had been troubled with acne, and all but one were better. One student who had a dry skin, especially on the face and hands, noticed a great increase in oiliness, and his nails were much less brittle. Three others noticed more oiliness of the hair. Two students, whose eyes tired easily, found that they could study longer before feeling any sense of eye fatigue. Of the five students who reported frequent headaches before taking the capsules, one had no headaches, three had fewer headaches, and the other had no decrease in number but a decrease in severity. One student who had gums that bled easily noticed considerably less bleeding and more hardening of the gums while taking the additional vitamins.

We may, therefore, conclude that the ingestion of additional vitamins by a person who is in poor physical condition is likely to bring about a very considerable improvement in general health, especially in resistance to respiratory infections.

Occidental College.

Always Determine Cause of Baby's Crying.—The cause of a baby's continuous crying always should be determined, Ruth Peck McLeod, Knoxville, Tenn., and Hazel L. Creekmore, R.N., declare in their article, "Shall We Let the Baby Cry It Out?" in the January issue of *Hygeia, The Health Magazine.*

There is always a reason for a baby's constantly crying. It may be that he is hungry, in pain, too cold or too hot or is tired of lying in one position. It may be that he is spoiled, though seldom is this the case.

While it is not advisable to pick up the baby every time he whimpers, it is always wise to investigate continued crying. More experienced mothers can interpret the various types of crying, such as the crying from hunger and from pain.

Crying usually increases the infant's complaint. The baby who cries from thirst loses still more water, while the crying of a child who has difficulty in breathing only results in a stuffed-up nose. Babies may expend an astonishing number of calories by crying.

Sleep that comes as a result of exhaustion after crying seldom does a great deal of good.

Hair Straighteners May Cause Burns.—Two cases of intense burns received by Negroes from the use of hair straighteners are cited by Fredric Lewis, M.D., and John V. Scudi, Ph.D., New York, in *The Journal of the American Medical Association* for January 7.

One patient has retained, for seven years, a large depigmented area on the forehead. The other patient, observed recently, will no doubt retain his scars permanently.

Amiable barbers confess that bad burns may result from the imprudent use of hair straighteners. Because of their tendency to burn, their use is inadvisable except with great care or under the supervision of a qualified physician.

BEDSIDE MEDICINE FOR BEDSIDE DOCTORS

An Open Forum for brief discussions of the workaday problems of the bedside doctor. Suggestions of subjects for discussions invited.

CURRENT QUACKERY

I. DIET QUACKERY

Fletcher B. Taylor, M. D. (3135 Webster Street, Oakland).—Very new countries and very old countries may suffer from food insufficiency. Underpopulation and overpopulation present frontiers of nutrition which have certain points of resemblance. In both instances there may be insufficient food calories to support activity, or even life. In the new occupancy a lack of vegetables may cause scurvy. In the country saturated with people this same lack may develop or there may come general health impairment from insufficient fat-soluble vitamins. Adult osteomalacia developed in Austria during the World War through lack of green vegetables and dairy products.

We who now practice medicine in the United States may find deficiencies in the diets of our patients for a variety of reasons. Poverty is at work in city slums, carelessness may cause trouble at any economic level, and fads in eating may do harm especially in people of fanatic mind. Besides these factors there is a commercialism which uses the diet sheet as its medical reason for existence. Practitioners of this motive broadcast and write for newspapers. There is much opportunism in advertising. Any company producing foodstuff can win the eye or ear of its buying public by making claims which suggest medical approval. The citizenry listens, reads and spreads the information further. Ultimately the information thus obtained is recited by patients in our offices. There is talk of combinations of foods, of drastic plans for reducing weight, of miraculous cures of serious illness by diet plans. Instead of supinely absorbing this lay effluvium, it behooves us to quarry our information from food authority. Some of the current interest in nutrition is due to real research advance.

Scientifically, a consideration of diet is often necessary; practically, a mention of diet is usually requisite in any constitutional disturbance. We must be patiently willing to provide "normal diets" to those who want such lists, even though their specific treatment does not require this information. The first question from the patient's relative or friend is, often, "What diet did the doctor prescribe?" If our advice to patients is to be worthy, it must rest upon active contact with good sources of information.

The human being is omnivorous. The fads which require patients to eat protein, fat, and carbohydrate separately have no basis in fact. We must guard against deficiency of calories and deficiency in food accessories in our patients. If the patient is undernourished, we must consider his problem from the standpoint of total calories eaten. Furthermore, the undernourished individual is more liable to avitaminosis than the well-nourished person. Question such a patient on food habits and fads, and on his family traditions of eating. Trace quantitative and qualitative defects to his period of growth if possible. Correct any such which may be discovered. Work toward well-established normal weight averages,[1] and body-build averages during the growth period.[2]

Look for vitamin deficiency in dermatoses, in persons with indolent pyogenic infections, in the night-blind, in hemorrhagic persons, in patients with neuritis, in those with impairment of heart function, in the rachitic, in the patient with irritable colon or with kidney stones. These and other conditions may rest in whole or in part upon inadequate vitamin intake. Vitamin deficiencies are well discussed in the text by Leslie J. Harris, entitled "Vitamins in Theory and Practice" (Cambridge University Press, 1937). Mineral deficiencies should be suspected in rickets, in tetany, and in abnormal bone fragility. The undernourished and underdeveloped person may not eat enough mineral. Schmidt and Allen discuss this subject of mineral metabolism ably and readably in their recent text, "Fundamentals of Biochemistry" (McGraw-Hill Book Company, 1938).

We must guard against deficiencies of quantity or quality of food in diabetes, in allergic persons who have been put upon exclusion diets and in the poor and indigent. While we consider faults of supply we must also consider faults in delivery to functioning tissue, absorption of food from the digestive canal, internal chemical processes, and in endocrine disturbances; but here we are considering external supply only. The food deficits of war time are like those of overpopulated countries. Interesting accounts which correlate these deprivations are those by Cleon Mason[3] and E. V. McCollum.[4] Of collateral interest is a presentation of food costs by Michael M. Davis, who considered the problem of feeding underpaid city dwellers.[5] Alonzo E. Taylor is co-author in an outline of the problem of feeding the world.[6]

It is surprising that we have so little recognized dietary deficiency, but the human organism can be wonderfully adaptable to abnormal conditions. Successful life on the remarkable diets of former diabetic regimens are in point. Voluntary rationing in and out of wartime is very illuminating.[7]

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[1] Davenport, C. B.: Body Build and Its Inheritance, Carnegie Institute, Washington, Publication 329, 1923.

[2] Pryor, H. B., and Stolz, H. R.: Determining Appropriate Weight for Body Build, Jour. Ped., Vol. 3, No. 4, pp. 608-622 (Oct.), 1933.

[3] Mason, Cleon C.: German Nutrition, Johns Hopkins Hospital Bulletin, 31:349 (March), 1920.

[4] McCollum, E. V.: Scientific Nutrition and Public Health, Hygeia, 1:93 (May), 1923.

[5] Davis, Michael M.: Food in Families of Limited Means, The Survey, 39:413 (Jan. 13), 1918.

[6] The Food Problem. Kellog and Taylor. Macmillan, 1918.

[7] Roth, Paul: The Civilian War Ration, J. A. M. A., 71:952 (Sept. 21), 1918.

Stefansson's famously successful meat-and-fat diet is surprising in this regard. These recorded experiences are reassuring on the adaptability of humankind to special conditions, but should not encourage a blind confidence as we prescribe for patients.

In dealing with the individual patient across the desk or in the hospital, we gain help from the "Compilation of Diets" by the California Dietetic Association (Spanish-American Institute Press, Gardena, California, ninth year). The Department of Household Science of the University of California furnishes a list of recent progressive texts upon the various special problems of nutrition. A sensible dietitian may be consulted with great help. Dietitians are beginning to construct diet plans in which there is quiet conformity to scientific need in really attractive menus. The pleasure of eating is still a consideration in this country.

With the above and similar sources of information, we may guard against diet quackery in ourselves and others.

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II. COSMETIC QUACKERY

Samuel Ayres, Jr., M.D. (2007 Wilshire Boulevard, Los Angeles).—Eternal youth, like perpetual motion, is a goal which the frailty of human understanding has never permitted mankind to acknowledge as being unattainable. It is a worth while and laudable desire for one to look one's best. In so far as the use of cosmetics can contribute to this end, they serve a useful purpose. The extent to which they should be used depends upon the rules of good taste. The desire on the part of the public for the unattainable, and the facility on the part of cosmetic manufacturers and distributors to promise the unattainable, constitute a vicious circle which becomes so vicious at times that serious injury or death may be the outcome.

Cosmetic manufacturers and beauty shops have enjoyed far too great an immunity from regulations which govern the ordinary preparation and dispensing of drugs on the grounds that cosmetics are neither foods nor drugs and, therefore, should not be regulated by pure food and drug laws, and that beautifying the body does not constitute the practice of medicine.

As the result of such loopholes, an enormous amount of quackery has developed. It would be bad enough if it were only a matter of selling "skin foods" that failed to nourish or hair growers that failed to produce a crop. Much more serious consequences of what might be called cosmetic racketeering not infrequently come to the attention of dermatologists. Cosmetic quackery can very easily be roughly divided into minor and major quackery, and all of these quackeries depend upon three factors: the desire of some of us to be good looking; the desire of some of the rest of us to exploit this desire either honestly or dishonestly; and, finally, the almost complete ignorance of both parties to the exploitation of fundamental facts of physiology.

1. "Skin foods," "nourishing creams," and "wrinkle removers." In the first place, wrinkles may be caused by three main factors: senility, with an associated atrophy of fat tissue, elastic tissue and a general thinning of the dermal structures, with a consequent redundancy of the overlying epithelium which falls into folds; appreciable loss of weight from illness or other causes, resulting in a relaxation and wrinkling of the epidermis following the disappearance of underlying fat; excessive dryness, which causes a very superficial, fine wrinkling especially about the mouth.

There is no physiological evidence whatever that substances rubbed into the skin nourish the skin at the point of application. On the contrary, all authorities agree that any fatty or nourishing substances thus applied to the skin are absorbed by the lymphatics and transported to other parts of the body, where they undergo the same processes of digestion and assimilation as though they had been taken by mouth. If the term "lubricating cream" were substituted for the term "skin food," there would be no criticism. Inasmuch as suitable fatty or lubricating substances soften the skin when it is dry and rough, they perform a useful function and constitute a legitimate cosmetic. But "skin food" seems to promise so much more and, psychologically, certainly has a much stronger sales appeal! There is no scientific foundation for the claim that hormones incorporated in creams can change the quality of the skin, and the fact that people are willing to pay exorbitant prices for such preparations is eloquent testimony to the ignorance of the public and the cupidity of the manufacturers.

2. Skin cleaners, cleansing creams, etc. Cleansing the skin should be, and in fact is, a relatively simple matter. Warm water and soap which is free of excess alkali and medication constitute the ideal cleansing medium. Soap dissolves or mechanically removes dirt, excess oil either naturally produced or cosmetically applied, and various other substances from the surface of the skin. If the coating of cosmetics is unusually heavy, it can first be softened with cold cream and then washed off with soap and water. The day's accumulation of natural sebum, dirt, powder, rouge, cream, etc., can be effectively removed only by the use of soap and water. The sebaceous orifices become clogged with such débris and, while it is true that "cleansing" creams will remove dirt from the skin surface, they cannot adequately cleanse the pores. On the contrary, rubbing "cleansing" cream on the face adds to the accumulation already clogging the sebaceous outlets.

The author has for a number of years been interested in a clinical disorder which affects the face chiefly in women, and especially those who have substituted "cleansing" creams for soap and water. The condition is characterized by a dryness and roughness of the face, the roughness being due to the plugging of the sebaceous pores by innumerable tiny scale-like plugs which feel like the surface of a nutmeg grater. In addition to the dryness and roughness, there is more or less redness, and sometimes superficial vesicopustules, constituting a veritable acne rosacea. These patients complain a great deal of burning and irritation, which is not relieved by any sort of soothing cream or ointment. If several of these dry follicular plugs be picked out with fine-pointed forceps, or a drop of the fluid from one of the vesicopustules be removed on the point of a narrow scalpel, and placed on a glass slide and covered with a cover slip after the addition of a drop of 40 per cent KOH, and then examined under the low power of the microscope, one is apt to find enormous numbers of Demodex folliculorum, a small animal parasite, normally present in small numbers in the upper portion of the sebaceous ducts on the face. Under normal conditions these parasites apparently act as scavengers, subsisting on sebum, and cause no irritation, but in the absence of soap and water cleansing, and especially with the abundant use of cosmetics, living conditions seem to become more favorable for these organisms, which multiply rapidly. I have counted as many as sixteen Demodex within a single follicular scale in a low-power microscope field, lying side by side and looking almost like sardines packed in a can. These organisms are never found in such numbers in normal skin nor in any other dermatosis of the face such as acne vulgaris, impetigo, sycosis vulgaris, etc. The above described entity might very properly be designated as "cosmetic skin." As further evidence that this condition is caused by improper cleansing of the skin, with a resultant expansion of the Demodex colony, one need only observe the rapid disappearance of the disorder following the institution of daily washing with soap and water, followed for a few nights by the application of a compound sulphur ointment, such as Danish ointment, which appears to be as effective in killing Demodex folliculorum as it is in destroying acarus scabei. For tender skins, a little simple cold cream applied after washing with soap and water would be of value.

Other types of cleansing agents have been advertised. One, a liquid, appears to contain a rather sizeable percentage of phenol, judging by its odor which persists for many minutes after an application. The daily absorption of phenol, which is rubbed into the skin over an indefinite period of time, certainly carries the danger of kidney damage. Strongly medicated soaps have little, if any, therapeutic value, and certainly offer ample opportunity for local irritation.

3. Depilatories. The growth of superfluous hair, especially on the face in women, is frequently a source of embarrassment and, if heavy, is a disfigurement and may be a serious handicap, both psychically and economically. The only safe and effective method of *permanent* removal is by means of electrolysis. When properly performed, good results can be obtained. For a number of years, and possibly even now in some states, x-rays were employed for this purpose. Qualified dermatologists and roentgenologists have long recognized the fact that a dose of x-ray sufficient to destroy the hair follicles would also destroy other structures of the skin such as elastic tissue, sebaceous glands, etc., resulting in a chronic roentgen dermatitis, giving the effect of a prematurely senile skin with the dangers of malignant degeneration. In spite of these facts having been definitely established for twenty years or more, certain "beauty" charlatans have continued to advertise and to administer x-rays for such an illegitimate purpose, with the result that all x-ray therapy is falling into disrepute in the minds of many laymen, and hundreds of women have had their faces permanently disfigured. It is true that ultimately such abuses are corrected more or less, here and there, but there is always a long period of time, sometimes from ten to twenty years, during which irreparable harm is done, to the enrichment of the unscrupulous.

Another vicious depilatory was put on the market several years ago, while advertised in metropolitan newspapers by leading department stores. This substance was a cream which could be bought by anyone, and carried no word of warning that it contained a deadly poison—thallium acetate—which, in other forms, has been widely used as a rodent exterminator. Absorbed through the skin, this cream not only caused the hair to disappear locally, but also in many cases resulted in baldness, blindness, paralysis, and death.

Of the more commonly used depilatories, some consist of a wax which is melted, applied to the skin and allowed to harden. It is then pulled off, pulling with it the hairs which have become embedded in the solid mass. "It's off, because it's out," is true as far as it goes; but pulling the hair out, whether done by wax or by tweezers, does not destroy the growing part of the hair, in spite of the statement of the manufacturer that continued use of the product tends to discourage the growth of the hair. Other depilatories contain barium sulphid, which dissolves the hair shaft a little distance below the surface of the skin but does not accomplish much more than shaving. Provided one is not sensitive to barium sulphid, there is as yet no known contraindication to using such a preparation. If the growth of superfluous hair is truly excessive, the advice of an endocrinologist should be sought.

4. Antiperspiration cosmetics. The use of preparations under the arms for the purpose of inhibiting perspiration or disguising its odor is usually without harm, unless one happens to be sensitive to some ingredient in the cosmetic, which not infrequently happens. Aluminum chlorid, oxyquinolin sulphate, formaldehyd, formic acid, salicylic acid, thymol, etc., are some of the active ingredients in such preparations, which are capable of exciting a dermatitis. Once a dermatitis has developed, secondary pyogenic infection often supervenes, with the formation of multiple painful furuncular lesions of the sebaceous and large sweat glands. None of these preparations exert any permanent remedial action.

5. Hair restorers. The high percentage of baldheaded men, even among the dermatological profession, is ample testimony of the inadequacy of most of our methods for growing hair. The claims of most hair tonic manufacturers and hair-growing "systems" rank near the front in optimism, but usually bring up in the rear in performance. The truth of the matter is that no one knows the cause of premature baldness. Male, sex-linked racial and hereditary factors are probably of great importance. Toxic influences, such as acute and chronic

illness (alopecia following influenza, scarlet fever, occasionally in syphilis), possibly toxic absorption from chronic foci of infection in certain cases, chemical toxins such as arsenic and thallium, mechanical obstruction to scalp circulation from tight-fitting hats on rounded or oval heads, local infection of seborrheic dermatitis, endocrine disorders such as hypothyroidism with dryness and thinning of the hair—one or more of these factors, and doubtless others of undetermined nature, probably account for baldness. No experimental work of any value has been offered to show that external applications can stimulate the growth of hair except in cases of alopecia areata, where irritants, especially ultraviolet light in brisk doses, apparently is of some value in cases of not too great extent or of too long duration. Preparations containing sulphur, salicylic acid, etc., which are capable of controlling the infective process in cases of seborrheic dermatitis, are probably of value in arresting hair loss. It would probably be conservative to say that nine-tenths of the claims of hair-growing preparations and "systems" are unwarranted.

6. Face rejuvenators. These preparations range all the way from mild "astringents" to clay packs, to face peels, to subcutaneous injections of paraffin for the removal of wrinkles. The milder "astringent" preparations are usually harmless and may give temporary benefit by setting up a mild superficial inflammation of the skin, with slight swelling, thus causing enlarged "pores" or sebaceous orifices to appear smaller. Alcohol, alum, witch hazel, benzoin, glycerin, menthol, etc., in various combinations usually make up such preparations. They do not cause any actual contraction of the sebaceous openings, and their effect, if any, is very transitory. The only effective method of actually reducing the size of enlarged sebaceous orifices, which is usually due to overactivity of the sebaceous glands, is to depress the activity of these glands by small, divided doses of x-ray in the hands of one qualified to use this agent in the treatment of skin disorders. Digestive and dietary factors should not be overlooked. Alcoholic stimulants usually cause a reflex flushing of the face, with an accompanying overstimulation of the oil glands.

Clay packs give a feeling of luxury and comfort, but no scientific evidence has been adduced to indicate any therapeutic effects worthy of note.

Face peels are supposed to remove "blemishes," wrinkles, scars, etc. Exfoliation induced by ultraviolet light is relatively superficial in its effects, is usually harmless, unless a severe burn is produced, and is likewise usually of little therapeutic value, although some benefit may at times be noted. Deep peeling, such as follows the use of certain chemical "face peels," is positively dangerous, and cases of permanent disfigurement, and even death, have been recorded from its use. Resorcin, sulphur, betanaphthol, etc., which are sometimes used, may cause a severe dermatitis, when phenol and other more dangerous ingredients are known to have been employed.

The subcutaneous injection of paraffin for the purpose of smoothing out wrinkles was at one time more widely employed than at present. The paraffin, being nonabsorbable, remained in the tissues, frequently setting up inflammatory reactions in the connective tissue with resultant paraffinomas, tumor-like swellings which frequently blocked lymph drainage, thereby causing edema, tumor masses, discoloration and, in general, a permanent and horrible disfigurement for which there is no known relief.

7. Bleaches, dyes, rouge, powder, etc. Space does not permit detailed consideration of all these cosmetics, but a few words will point out some of the hazards.

Many bleaches and freckle removers contain mercury, sometimes in dangerously high percentages. If there is no immediately irritating effect there may be toxic injury from absorption, if used over a long period of time, and in occasional cases the long-continued application of mercury creams results in a slate-gray pigmentation similar in appearance to argyria.

Hair and eyelash dyes occasionally produce a severe dermatitis or conjunctivitis. Anyone contemplating having his hair dyed should have a patch performed first to determine if sensitivity to that dye exists. This does not, however, insure against the subsequent development of a sensitivity with continued use of the dye. Paraphenylendiamin has resulted in blindness in a number of cases in which it was used to dye eyelashes, and occasional cases of severe dermatitis have followed its use on the scalp. Lead and silver are used in some dyes. Even henna has been known to cause local irritation.

Certain face powders at one time contained lead, but probably the great majority of powders on the market at present are free of injurious ingredients, unless one is sensitive to orris root, rice powder, or some coloring or perfume which may be present.

Lipstick and rouge are also usually harmless, except for the occasional case of sensitivity to some ingredient. Certain liquid nail-polish preparations may cause a dryness and splitting of the nails, due to the solvent action of acetone, etc.

In conclusion, let it be said that the use of cosmetics has a legitimate place in modern civilization. When tempered by the rules of good taste, the judicious use of cosmetics should enhance personal appearance, and cleanse and protect the epidermal coverings of skin, hair, and nails. Anything beyond this properly belongs in the field of medicine. If it were possible to eliminate the fraudulent claims and the worthless or dangerous preparations, there would be no quarrel. The public is entitled to this protection and it must be forthcoming. The Federal Trade Commission is one agency which is working on the problem, and should be sympathetically supported.

* * *

III. SUGGESTED REMEDIAL MEASURES

H. M. F. Behneman, M.D. (450 Sutter Street, San Francisco).—To outline remedial measures designed to end quackery is an easy assignment. To enforce and actually curb quackery is indeed a difficult problem. For a hundred years we really have been trying to accomplish this end in medicine; yet new cults are constantly springing up, and old ones—parasites clinging to the cloak of medicine—are still with us. Probably no one in our State Medical Society is more alert to the situation than our able Medical Board secretary, Doctor Pinkham. His opinion is that the only real, potent, lasting remedy is education of the public.

This, he feels, is possible, and will eventually bring the greatest results. Such education, however, must start in the primary schools—it must start with the growing child. He must be given enough knowledge of elementary physiology and hygiene so that he will, as he grows older, naturally seek medical care from those he feels are qualified to "know whereof they speak." Meanwhile our efforts to reach the adult mind must go on by radio, by print, and by word of mouth. Teach the growing child and the grown-up enough about the basic sciences to enable him to judge who is best qualified to treat his ills.

My own ideas center around legislation. I have felt the Basic Science Law is a panacea par excellence. However, it is only effective if no initiative measure or law exists in the state. Legislative enactment would not be effective in such a situation. In other words, such a law must become a law by a vote of the people. A certain (and large) percentage of those who voted in the previous election must vote "Yes" on such a measure to place it in our statutes. This is not only difficult in California, but costly. Thirteen states now enforce a Basic Science Law. Such a law determines whether a person is well enough informed in the five sciences fundamental to all methods of healing. Our present method of three separate examining boards only causes confusion. Too often they fail to enforce their own acts, and the result is the State Board of Medical Examiners has to step in and prosecute.

To control charlatanism by hospital coöperation, etc., is useless, because the cultists are building their own, such as the Bellevue Hospital in Los Angeles. May I meekly suggest that we emerge more often from the smug stronghold of our superethics to inform the public better as to why they should seek a physician and not a cultist! We cannot ignore the fact that salesmanship and advertising have turned millions into the cultists' waiting arms. Hippocratic medicine has nothing to hide and much more to give. We should use every approved method to inform the public, particularly now when we are on the threshold of socialized medicine, with the *laity* hard at work on plans for *our* future.

Inform the growing child, interest your patients in its importance; then, perhaps, in a few years we can successfully vote a Basic Science Law into California.

The Indictment of the American Medical Association.—Last week *The Journal* published the complete text of the indictment of the American Medical Association and other defendants, in the District of Columbia, by a grand jury which, for some weeks, had heard a mass of evidence presented to it by attorneys from the Department of Justice, *The Journal of the American Medical Association* for January 7 says in an editorial.

Elsewhere in the current issue of *The Journal* appears a chronology of this case from the time when the so-called Group Health Association, Inc., first appeared on the scene in the District of Columbia to the time when the grand jury made its report. Also in the Organization Section will be found a number of editorials and cartoons which have appeared in newspapers throughout the United States indicating, as far as such pronouncements can indicate, the public reaction to this extraordinary indictment.

At the special session of the House of Delegates which was held in Chicago in September, the Board of Trustees of the American Medical Association, anticipating the Government's activities, presented a consideration of the possibility of an indictment. This matter was referred by the House of Delegates, as is customary, to a reference committee and the report of the reference committee was unanimously adopted by the House of Delegates. This report authorized the Board of Trustees to employ suitable legal counsel and to carry this matter even to courts of last resort in order to determine the issue.

Apparently the press of the United States finds it impossible to separate the activities of the Department of Justice from the proposal of a vast expansion of medical service under governmental control. Thus Gerald G. Gross, in the Washington *Post* of December 25, writes: "A convincing case can be built up to support the theory that the extraordinary grand jury study was, to put it bluntly, propaganda looking forward to Congressional consideration of the proposed National Health Program."

The commentators in the American press, including even those newspapers which have been most persistent in the campaign for new methods in medical practice, have been well night unanimous in their opinion that the action of the Department of Justice under Mr. Thurman Arnold was the wrong way to achieve the objective if that objective is to be achieved. Certainly this legal procedure can do nothing to solve the problem of medical care. It is a pity that the Federal Government, including its executive, investigate and a considerable number of other departments should have embarked on a procedure which is inclined to cast public discredit on a great profession and to impugn the motives of workers in that profession. Moreover, a suitable defense will cost the Association a considerable sum of money that in the ordinary course of events would have been spent for the advancement of the science and art of medicine and the protection and promotion of public health. The time may yet come when those representatives of our government who have been chiefly responsible for initiating, conducting and manipulating this performance with all of its far-flung manifestations will review regretfully the part they have played in this incident.

"Digestion" of Food Starts With Cooking.—The process of digesting your food starts while this food is being cooked, declares Hyman Goldstein, Ph.D., West Coxsackie, New York, in his article entitled, "Enzymes—Dictators of the Digestive System," in the January issue of *Hygeia, The Health Magazine.*

This "digestion" process starts with the breaking down of the complex protein, carbohydrate and fat molecules due to the action caused by application of heat when the food is placed on the stove. The process is then continued in the body after the food is eaten. The temperature of the body and the ever-present water in the juices of the digestive tract help to complete the breakdown.

The enzymes in the digestive juices speed up this simplification process. While their presence helps the digestive process along, they themselves do not enter into the reaction and are not used up. The enzyme may be likened to a spark that sets off an explosion, but unlike the spark it does not vanish when the reaction or explosion is over.

After the food is digested, it is probable that the enzyme, which is unchanged, is absorbed with the digested food by the body. It is also probable that the enzyme can be used over and over again. A minute quantity of enzyme can bring about chemical changes in large quantities of food. It must be made clear that enzymes merely accelerate the whole process of breaking down the food particles.

The first wealth is health. Sickness is poor-spirited and cannot serve anyone; it must husband its resources to live. But health answers its own ends, and has to spare; runs over, and inundates the neighborhoods and creeks of other men's necessities.—Emerson.

CALIFORNIA MEDICAL ASSOCIATION

This department contains official notices, reports of county society proceedings and other information having to do with the State Association and its component county societies. The copy for the department is submitted by the State Association Secretary, to whom communications for this department should be sent. Rosters of State Association officers and committees and of component county societies and affiliated organizations, are printed in the front advertising section on pages 2, 4 and 6.

CALIFORNIA MEDICAL ASSOCIATION†

WILLIAM W. ROBLEE	President
CHARLES A. DUKES	President-Elect
LOWELL S. GOIN	Speaker
KARL L. SCHAUPP	Council Chairman
GEORGE H. KRESS	Secretary-Treasurer

OFFICIAL BUSINESS

ASSOCIATION ACTIVITIES

1. *Council Minutes, Two Hundred and Seventy-First Meeting, January 14, 1939.*
2. *California Physicians' Service: Articles of Incorporation.*
3. *Hotel Rates for Del Monte Annual Session.*

DEPARTMENT OF PUBLIC RELATIONS

1. *Doctor Wilbur Head of New Health Plan.*
2. *Recommendations of the American Public Health Association to the Technical Committee on Medical Care.*
3. *President Roosevelt May Submit Health Program Today.*
4. *Text of Roosevelt Message Urging United States Health Program.*
5. *Cancer Commission of the California Medical Association.*
6. *Proposed Medical Legislation.*

COUNCIL OF THE CALIFORNIA MEDICAL ASSOCIATION

Minutes of the Two Hundred and Seventy-First Meeting of the Council of the California Medical Association

Meeting was held in Room 209, Sir Francis Drake Hotel, San Francisco, Saturday, January 14, 1939, at 9 a. m.

1. **Call to Order.**—The meeting was called to order by Chairman Schaupp with the following members present: President William W. Roblee, President-Elect Charles A. Dukes, Past President Howard Morrow, Speaker Lowell S. Goin, Chairman of Council Karl L. Schaupp; Councilors Calvert L. Emmons, Louis A. Packard, Axcel Anderson, Alfred L. Phillips, Oliver D. Hamlin, P. K. Gilman, F. N. Scatena, Henry S. Rogers, T. Henshaw Kelly, William H. Kiger; Chairman of Public Relations Committee George G. Reinle, Secretary-Editor George H. Kress, General Counsel Hartley F. Peart, and his associate, Howard Hassard.

Absent: C. O. Tanner, abroad; Carl R. Howson and Harry H. Wilson, because of illness.

2. **Minutes.**—The minutes of the 270th meeting of the Council were presented and on motion of Howard Morrow, seconded by William Kiger, were approved.

3. **Pneumonia Control Committee.** — Discussion was had of the payment of transportation expenses of members of committees.

It was moved by William Roblee, seconded by Calvert Emmons, that the Chairman of the Subcommittee on Pneumonia Control be invited to be present at the Conference of County Society Secretaries and Standing Committees, to be held on Saturday, February 18. Carried.

4. **Trustees of Indemnity Defense Fund.**—On nomination by Howard Morrow, seconded by Charles Dukes, and ballot duly cast, J. B. Harris was elected trustee of the Indemnity Defense Fund for a period of three years, term expiring 1942.

5. **Special Session Costs.**—Secretary Kress reported that the cost of the special session of the House of Delegates to date was $4,557.15. (Transportation, $2,316.95; per diems to delegates, $1,050; mimeographing tentative drafts, $544.44; ediphone reporting, $232.40; miscellaneous, $413.36; reports from three delegates not yet received.)

6. **Audit.**—The Secretary reported that the certified public accountants were at present preparing an audit of Association accounts for the year 1938.

7. **Contribution from a Delegate.**—The Association Secretary stated that a delegate had returned the check to the Association, which had been sent to him to cover transportation expense for attendance at the special session in Los Angeles.

It was moved by Howard Morrow, seconded by William Kiger, that the Association Secretary be given power to act. Carried.

8. **Retired Membership.**—The San Francisco County Medical Society having recommended for retired membership Dr. Alexander T. Leonard, it was moved by William Roblee, seconded by William Kiger, that Alexander T. Leonard be granted such membership in the California Medical Association. Carried.

9. **Annual Session.**—Upon request for instructions from the Committee on Program for Del Monte Annual Session, to be held May 1 to 4, 1939, the consensus of opinion of the Council was that a portion of the first general meeting should be devoted to a discussion of the medical service plan as contemplated by the California Physicians' Service.

It was moved by Howard Morrow, seconded by William Kiger, that Dr. Rock Sleyster, President of the American Medical Association, be invited to address the members of the California Medical Association. President Roblee was instructed to extend the invitation to Dr. Rock Sleyster.

The Secretary stated that other invited guests for the annual session as selected by the Committee on Scientific Work were Dr. Chester Keefer of Boston, Dr. Stuart Harrington of the Mayo Clinic, and Dr. Victor Portman of the Cleveland Clinic.

It was moved by George Reinle, seconded by William Kiger, that the recommendations of the Committee on Scientific Work in regard to invited guests be approved. Carried.

10. **Prizes for Scientific Exhibits.**—The Committee on Scientific Work suggested that the cash prizes for scientific exhibits be discontinued and that in lieu thereof three engrossed certificates (one for excellence. the others for honorary mention) be awarded.

Upon motion duly made and seconded, the recommendation of the Committee on Scientific Work was adopted.

11. **Entertainment at Annual Session.**—It was moved by William Kiger, seconded by A. E. Anderson, that the question of allocation for entertainment at the president's

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† For complete rosters of officers, see adv. pages 2, 4 and 6.

dinner be referred to the Chairman of the Auditing Committee and the Association Secretary. Carried.

12. **Association of Western Hospitals.**—It was moved by Lowell S. Goin, seconded by William H. Kiger, that the Secretary advise the Association of Western Hospitals that the California Medical Association would suggest a speaker for its meeting in Seattle, provided the transportation and hotel expense of such speaker were paid by the Hospital Association.

13. **Delegates.**—A letter from the San Francisco County Medical Society requesting that the names of delegates and alternates be printed as submitted by the Society in the order of number of votes received, with numbers of votes received by each, in lieu of the alphabetical arrangement in use during the last several years, was presented for consideration. The difficulties were pointed out, if this method were applied to all county societies. It was agreed that the listing as recommended by the San Francisco County Society should be used for that component unit, as per its request.

14. **Death of Citizen.**—The Secretary presented a letter asking for an investigation of the death of a citizen of San Luis Obispo. It was suggested that the communication be referred to the Division of Vital Statistics of the California Board of Public Health.

15. **Cancer Campaign.**—Doctor Dukes stated that the Cancer Commission desired the approval of the Council of the participation of the Woman's Auxiliary. The Council saw no objection to such participation if carried on under the direction of the Cancer Commission.

16. **Executive Committee.**—It was moved by William H. Kiger, seconded by C. L. Emmons, that all items on the present Council docket not receiving consideration at this meeting be referred to the next meeting of the Executive Committee. Carried.

17. **Medical Service Plan — California Physicians' Service.**—Dr. Charles A. Dukes presented the report of the special committee on medical service plans in which the work of the committee, subsequent to the special meeting of the House of Delegates in Los Angeles December 17-18, 1938, was summarized. Doctor Dukes also presented the report of General Counsel Peart and Associate Counsel Howard Hassard to the committee, the Articles of Incorporation of California Physicians' Service as revised by the General Counsel, and the proposed by-laws of California Physicians' Service as revised pursuant to the recommendations of the House of Delegates.

Consideration was then given to each item contained in the report of the special committee.

Doctor Dukes reported that each of the councilors and officers of the Association are to become the first administrative members of California Physicians' Service and that by two-thirds vote of all members, additional administrative members could be chosen from the membership of the Association. Thereupon, by the affirmative vote of all councilors and officers present, the following members of the California Medical Association were elected to administrative membership in California Physicians' Service to join with the members of the Council in incorporating the new corporation: Ray Lyman Wilbur of Stanford University, Dewey R. Powell of Stockton, W. Earl Mitchell of Berkeley, John C. Ruddock of Los Angeles, Fred B. Clarke of Long Beach, John W. Green of Vallejo, S. J. McClendon of San Diego, C. Kelly Canelo of San Jose, Alson R. Kilgore of San Francisco, Samuel Ayres of Los Angeles.

Communications from the American Medical Association were presented to the Council and upon motion of Doctor Packard, seconded by Doctor Morrow, Doctors Leland and Woodward were thanked for their interest and offer of coöperation.

Returning to the report of the special committee, Doctor Dukes stated that the House of Delegates had adopted a resolution authorizing a loan in the maximum amount of $15,000 to California Physicians' Service and that under the constitution of the California Medical Association, it was necessary for the Council to approve the resolution of the House of Delegates. Thereupon, upon motion of Dr. Lowell S. Goin, seconded by Dr. George G. Reinle, and unanimously carried, the following resolution was adopted:

> *Resolved*, That this Association, California Medical Association, loan and advance to California Physicians' Service, the California nonprofit medical service corporation about to be formed, sums not to exceed in the aggregate the sum of Fifteen Thousand ($15,000) Dollars, without interest, and that said loans be evidenced by the promissory notes of said corporation, payable one year after date; and be it
>
> *Further Resolved*, That the officers of this Association be and they are hereby authorized, empowered, and directed to carry this resolution into effect.

The Council proceeded with its consideration of the report of the Special Committee on Medical Service Plans. Mr. Peart stated that the preamble to the Articles of Incorporation had been revised since the meeting of the House of Delegates and the preamble as revised was thereupon read and approved.

Mr. Peart stated that the law requires articles of incorporation to set forth the name of the corporation to be formed, the county in which the principal office is to be located, the number and names of the first board of trustees and the authorized maximum number of administrative members. Therefore, the Council proceeded to consider and determine the various matters thus stated to be required by law.

(a) *Name.*—It was moved by Doctor Goin, seconded by Doctor Kelly, that the name "California Physicians' Service" be approved and adopted. Carried.

(b) *Principal Office.*—It was moved by Doctor Goin, seconded by Doctor Morrow, that the county in which the principal office of California Physicians' Service is to be located be designated as the city and county of San Francisco. Carried.

(c) *Maximum Authorized Number of Administrative Members.*—It was moved by Doctor Goin, seconded by Doctor Morrow, that the authorized number of administrative members be set at a maximum of seventy-five. Carried.

In reply to inquiries, Mr. Peart stated that the administrative members of California Physicians' Service will have the sole and exclusive voting power in the corporation and as such, voting members will from time to time elect the board of trustees and that the board of trustees will be charged with the management and supervision of the organization. Mr. Peart also stated that administrative members will have the exclusive right to amend the Articles of Incorporation from time to time if such becomes necessary and with the trustees will have the right to adopt, amend and repeal the by-laws. Mr. Peart stated that administrative members would undoubtedly be required to remain in contact with professional members in their respective administrative districts, but that their duties would not require an undue amount of time and that, after the first year, it would only be necessary to hold one general meeting of administrative members per year.

(d) *Board of Trustees.*—Doctor Dukes reported that the special committee recommended a board of seven trustees. Thereupon, it was moved, seconded and carried, that the number of trustees be fixed at seven. The following members of the Association were then submitted by Doctor Dukes on behalf of the special committee as the first board of trustees: Ray Lyman Wilbur, Stanford University; C. Kelly Canelo, San Jose; W. Earl Mitchell, Berkeley; T. Henshaw Kelly, San Francisco; Alson R. Kilgore, San Francisco; Lowell S. Goin, Los Angeles; Samuel Ayres, Los Angeles.

On motion duly made, seconded and unanimously carried, each of the foregoing members was elected a trustee of California Physicians' Service.

Chairman Schaupp then designated members of the Council immediately to communicate with each of the above selected trustees to communicate to them the action of the Council and to request their acceptance. The Council adjourned for five minutes and, upon reconvening, it was announced that each of the members selected as trustees had been notified and had accepted.

Association Secretary Kress was then instructed to notify each of the members of the Association selected as administrative members by the action of the Council by telegraph and to request their acceptance of administrative membership in California Physicians' Service.

(e) *Invitation to Be Extended to Representative Californians to Become Administrative Members.*—After discussion it was the sense of the Council that a selected group of persons who are not members of the California Medical Association should be invited to become administrative members of California Physicians' Service. It was moved by Doctor Morrow, seconded by Doctor Goin, that a committee be appointed by the Chairman to canvas the councilors present and to suggest names of nonmedical Californians for the consideration of the Council. Carried.

The Chair appointed Doctors Roblee, Gilman, Kiger, Reinle, and Rogers.

On behalf of the special committee appointed by Chairman Schaupp, Doctor Roblee then submitted a suggested list of names of lay citizens for invitation to become administrative members of California Physicians' Service. . . .

(f) *Revised By-Laws.*—The proposed by-laws of California Physicians' Service, as revised to incorporate the various recommendations made by the House of Delegates, were then presented to the Council for its consideration. Each of the sections of the proposed by-laws which had been changed in any manner from the tentative draft presented to the House of Delegates, was then read to the Council and discussed.

Mr. Peart stated that, in accordance with the recommendation of the House of Delegates, the manner of selecting and electing administrative members had been changed so that administrative members would hereafter be elected by the professional members by administrative districts, the number of administrative districts to be not less than ten and not more than thirty. After discussion, it was determined that each administrative district should be entitled to two administrative members. As thus revised, this portion of the by-laws was approved.

The Council continued with a consideration of various portions of the by-laws. Mr. Peart stated that those sections which were routine and which had been left blank in the tentative draft submitted to the House of Delegates, had been completed and, as completed, said sections were read to the Council.

Thereupon, by motion duly made, seconded and carried, it was determined that the proposed by-laws, as now revised, be forwarded to the board of trustees of California Physicians' Service upon incorporation of California Physicians' Service with the recommendation of the Council that said by-laws be adopted.

18. **Farm Bureau Conference.**—Doctors Packard, Anderson, Rogers, and Mr. Hassard outlined the discussion and action taken at the Conference of the Special Committee of the Association and the Farm Bureau representatives held on January 13, 1939.

It was moved by Louis Packard, seconded by A. E. Anderson, that the County Hospital Bill, as outlined in the report of the committee, be recommended to the Legislative Committee and that they give it support, and it be allowed to follow the course as outlined. Carried.

19. **Exemption of Medical Books.**—On motion duly made, seconded and carried, the matter of exemption of medical books in libraries was ordered laid on the table.

20. **Nurses' Bill.**—The proposed California Nurses' Bill was discussed, and on motion of Charles Dukes, seconded by George Reinle, was referred to the Legislative Committee.

21. **Opticians' Legislation.** — Proposed legislation for the establishment of a licensing board for dispensing opticians was discussed. Doctor Kelly stated he felt that the most desirable method of procedure would be to amend the present law.

It was moved by T. Henshaw Kelly, seconded by Lowell Goin and Louis Packard, that the Council instruct the Legislative Committee to draft the necessary amendments for the Business and Professions Code to secure the right of dispensing opticians to dispense glasses under prescription by licensed doctors of medicine without acting under the jurisdiction of the Board of Optometry. Carried.

22. **Adjournment.**—There being no further business the meeting adjourned.

George H. Kress, *Secretary.*

Attest:

Karl L. Schaupp, *Chairman.*

CALIFORNIA PHYSICIANS' SERVICE: ARTICLES OF INCORPORATION*

Know All Men by These Presents That:

We, the undersigned, all of whom are residents of the State of California, and active members of the California Medical Association, a voluntary association originally formed March 12, 1856, now having its office and headquarters at Room 2004, Four Fifty Sutter Building, 450 Sutter Street, San Francisco, California, with the approval of said association heretofore duly given, and after more than ten years of continuous investigation and study by the said association, do hereby declare that the duties and obligations of the profession are not only leadership in the maintenance of high standards of medical service but also in the means of distribution of that service so that all who need it may receive it; that the very advances made by modern science have greatly increased the cost of good medical service and hospital care and will continue to increase that cost as new methods and equipment for diagnosis and treatment are discovered and perfected, and, therefore, the cost of always unpredictable injury or illness is a financial catastrophe too great to be borne by the few citizens of California thus always afflicted at any given time, although the total cost over any period is within the means of the total group; that a method which only the medical profession can most effectively provide is necessary properly to distribute this cost of medical service so as to relieve the intolerable financial burden heretofore falling on the unfortunate few in any given period of time; that the establishment by the profession of a voluntary medical service plan, participated in by all doctors of medicine desiring to do so, will enable the people of the State of California to obtain prompt and adequate medical attention and hospital care whenever needed on a periodic budgeting basis without injury to the standards of medical service, without disruption of the proper physician-patient relation and without profit to any agency, and will assure that all payments made by patients, except administrative costs, will be utilized for medical service and hospital care and not otherwise; that such a plan will create an efficient public and civic service without commercial exploitation of the patients or the profession or any restriction of an individual's fundamental right freely to select, when his need arises, the doctor of medicine and hospital desired by him; and finally, such a coördinated organized service can, upon the same fundamental basis, be the means which governmental agencies—federal, state, and local—may use to provide, at the lowest possible cost to the taxpayer, good medical service and hospital care for the indigent, needy or handicapped residents of California.

Wherefore, with the approval of the organized medical profession of the State of California, we, the undersigned, propose to form a nonprofit, social and civic corporation under the laws of the State of California and particularly as embodied in Article I, Title XII, Part Four, Division First, of the Civil Code of the State of California, and for the purpose of such incorporation we hereby unite in and adopt the following articles of incorporation, to wit:

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* For the information of members of the California Medical Association, and for purposes of record, the Articles of Incorporation are printed in this issue. For other related items, see pages 81, 138, 153 and 164.

One: The name of this corporation is California Physicians' Service.

Two: This corporation does not contemplate and is not formed for the pecuniary gain or profit of the members thereof or the distribution of gains, profits or dividends to any of its members. The purposes for which this corporation is formed are:

1. The establishment and maintenance of a fund obtained by means of periodic payments by its beneficiary members and to be used to defray the cost to such beneficiary members of medical services, hospital care and other health services and facilities or medical services or hospital care alone or in conjunction with other health services and facilities.

2. To furnish and supply to those persons eligible for and admitted to beneficiary membership herein, hospital and nursing service at the lowest cost consistent with due and adequate care on a periodic payment plan in hospitals now or hereafter organized and established in the State of California, whose organization and management evidence that they are qualified to render and are actually rendering economic and efficient hospital care to the sick and injured.

3. To enter into, make, perform and carry out contracts with hospital service corporations now or hereafter operating hospital service plans on a nonprofit basis pursuant to Chapters 9 or 11A of Part Two, Division Two, of the California Insurance Code, under the terms of which contracts said nonprofit hospital service corporations may undertake to furnish maintenance and care in hospital, nursing care, drugs, medicines, physiotherapy, transportation, material appliances and their upkeep to beneficiary members of this corporation either directly or through hospitals with whom said nonprofit hospital service corporations may have contracted therefor.

4. To enter into, make, perform and carry out contracts for the performance of medical services by its professional members or for the furnishing of hospital care or both medical services and hospital care or for any other lawful object or purpose, with any public or municipal corporation, body politic, the State of California or any political subdivision of said State, any instrumentality, commission, board, bureau or other administrative agency of said State, the United States of America, or any department, bureau, commission or other administrative agency thereof, or any corporation incorporated under the laws of the United States or any foreign state.

5. To build, acquire, operate, equip, maintain, lease as lessee or lessor, mortgage, deed in trust, sell and otherwise dispose of hospitals, laboratories, drugs, medicines, medical and surgical apparatus, instruments and supplies and all other physical means and facilities for the relief, care and treatment of sick or injured persons.

6. And in aid and furtherance of the foregoing purposes:

(*a*) To act as trustee under any trust incidental to the principal objects and purposes of the corporation, and to receive, hold, administer and expend funds and property subject to such trust.

(*b*) To purchase, acquire, own, hold, lease either as lessor or lessee, sell, exchange, subdivide, mortgage, deed in trust, plant, improve, cultivate, develop, construct, maintain, equip, operate and generally deal in real and personal property of every kind or description.

(*c*) To enter into, make, perform and carry out contracts of any kind for any purpose without limit of any amount with any person, firm or corporation.

(*d*) To borrow money without limitation as to amount; to issue notes, bonds, debentures or other obligations of this corporation from time to time for any of the purposes of this corporation, and to secure the same by mortgage, pledge, deed of trust or other lien upon any or all of the property or assets of this corporation, or to issue the same unsecured.

(*e*) To lend money, purchase, acquire, hold on guaranty, sell, assign, transfer, mortgage, pledge or otherwise dispose of and deal in shares, bonds, debentures, notes or any other indebtedness of any person, firm or corporation and whether now or hereafter organized and existing; to exercise all the rights, powers and privileges of ownership thereof, including the right to vote thereon to the same extent as a natural person might, could or would do.

(*f*) To carry on any business whatsoever which this corporation might deem proper, or which might be calculated directly or indirectly to promote the objects and purposes of this corporation or to enhance the value of its service.

(*g*) To acquire all or any part of the good will, rights, assets and business of any person, partnership, firm, association or corporation heretofore or hereafter engaged in any enterprise, in whole or in part, similar to the objects and purposes of this corporation and to hold, utilize and in any manner dispose of the whole or any part of the rights and assets so acquired and to conduct in any lawful manner the whole or any part of the enterprise thus acquired.

7. To admit duly qualified persons to administrative, professional or beneficiary membership in the corporation and to suspend or expel any administrative, professional or beneficiary member for cause pursuant to the provisions of the by-laws.

8. To accept gifts, trusts and donations and receive property by devise or bequest, subject to the laws regulating the transfer of property by will, and to apply the principal or interest as may be directed by the donor or as the board of trustees of the corporation may determine in the absence of such directions, in aid and furtherance of the objects and purposes set forth in this paragraph Two.

9. To establish reserves and invest the funds thereof in bonds or in such other property as may be provided in the by-laws.

10. To levy assessments in such manner, upon such members and in such amount as may be provided in the by-laws.

11. To do all other acts necessary or expedient for the administration of the affairs and to attain the purposes of the corporation.

The foregoing statement of purposes shall be construed as a statement of both purposes and powers, and the purposes and powers stated in each clause shall be in nowise limited or restricted by reference to or inference from the terms of any other clause or paragraph of these articles. The objects, purposes and powers specified in each of the clauses or paragraphs in these articles shall be regarded as independent objects, purposes or powers. The enumeration of purposes and powers herein shall not be held to limit or restrict in any manner the general powers now or hereafter conferred on this corporation by the laws of the State of California or of the United States of America.

Three: The county in the State of California where the principal office for the transaction of the business of the corporation is to be located is the city and county of San Francisco.

Four: The names and addresses of the persons who are appointed to act in the capacity of directors until the selection of their successors and who shall bear the title and be known as trustees, are as follows:

Ray Lyman Wilbur, Stanford University.
C. Kelly Canelo, 241 East Santa Clara Street, San Jose.
W. Earl Mitchell, 2068 Allston Way, Berkeley.
Samuel Ayres, 2007 Wilshire Boulevard, Los Angeles.
Alson R. Kilgore, 490 Post Street, San Francisco.
Lowell S. Goin, 1930 Wilshire Boulevard, Los Angeles.
T. Henshaw Kelly, 490 Post Street, San Francisco.

Five: There shall be three classes of members, as follows: Administrative members, professional members, and beneficiary members.

1. Administrative members.

(*a*) The authorized number of administrative members of this corporation shall be seventy-five; the qualifications of the administrative members shall be as provided in the by-laws.

(*b*) The property, voting and other rights and privileges of administrative members are as follows: Every administrative member shall have the right to vote and hold office in the corporation, and all property, voting and other rights and privileges of each administrative member shall be equal to that of every other administrative member. Each administrative member shall be entitled to one vote on all matters and propositions submitted to such members and to one vote for each trustee to be elected by administrative members. Cumulative voting is expressly prohibited. The corporation shall have power by majority vote of the board of trustees to admit, and the board of trustees must admit, as provided in the by-laws, as administrative members, each person who is eligible for such membership, who shall be entitled to the same equal voting, property and other rights and privileges as then held and enjoyed by every other administrative member. All voting and property rights shall be vested in and held and enjoyed by the administrative members.

(*c*) Each of the incorporators hereof shall be qualified and eligible for administrative membership in this corporation and shall be an administrative member hereof.

2. Professional members.

(*a*) There shall be no limitation with respect to the authorized number of professional members; the qualifications of professional members shall be as provided in the by-laws.

(*b*) The property, voting and other rights and privileges of professional members are as follows: Professional members, as such, shall have no right to vote and no rights in the property of this corporation, except as provided in paragraph *Seven,* but every professional member shall have the right to hold office in the corporation and all rights and privileges of each professional member shall be equal to that of every other professional member. The corporation shall have power by majority vote of the board of trustees to admit, and the board of trustees must admit, as provided in the by-laws, as a professional member, any person who is eligible for such membership and who has, to the reasonable satisfaction of the board of trustees, agreed to abide by all rules and regulations with respect to the rendition of medical services or any of the activities of the corporation promulgated from time to time, as provided in the by-laws. Any person admitted as a professional member shall be entitled to the same equal rights and privileges as then held and enjoyed by every other professional member. Any professional member who is eligible to become an administrative member may be elected to administrative membership without loss of professional membership. Professional members shall have no right, title or interest in the property of the corporation.

(*c*) Professional members shall be liable equally to assessments or dues, or both, as may be provided in the by-laws.

3. Beneficiary members.

(*a*) There shall be no limitation with respect to the authorized number of beneficiary members; the qualifications of beneficiary members shall be as provided in the by-laws.

(*b*) The property, voting and other rights and privileges of beneficiary members shall be as follows: No beneficiary member shall have the right to vote or acquire or hold or possess any property right, or right, title or interest in or to any property or assets of the corporation, nor shall any beneficiary member have any rights or privileges other than as are provided herein and in the by-laws and in the certificate of beneficiary membership. The admission to beneficiary membership of duly qualified and eligible persons shall be effected as provided in the by-laws.

(*c*) Beneficiary members shall not be liable to assessments, but shall be liable to monthly, quarterly, semi-annual or annual dues, the prepayment of which shall be a condition to the privileges of beneficiary membership. The amount and method of collection thereof shall be as provided in the by-laws.

Six: (*a*) A roll of administrative members, a roll of professional members and a roll of beneficiary members shall be kept in a membership book and a certificate of administrative membership shall be issued to each administrative member admitted to such membership, a certificate of professional membership shall be issued to each professional member admitted to such membership, and a certificate of beneficiary membership shall be issued to each beneficiary member admitted to such membership. Issuance to and acceptance by a member of a certificate of membership in this corporation shall be conclusive evidence of the consent of such member to become a member of this corporation of the class to which admitted to membership and of his or her agreement to comply with and be governed by all of the provisions of these articles of incorporation, the by-laws of this corporation as then existing or thereafter amended, and all rules and regulations promulgated from time to time by the board of trustees pursuant to authority contained in the by-laws.

(*b*) Neither membership in this corporation, whether administrative, professional or beneficiary, nor any certificate evidencing the same, nor the interest of any administrative member in this corporation or any of the property or assets thereof shall:

1. Be subject to execution or become or be an asset of the estate of any deceased member or of any member who may become insolvent or bankrupt;

2. Descend to or vest in the heirs, legatees or devisees of any member; or

3. Be transferable or assignable in any form either by the voluntary or involuntary act of any member or by operation of law.

(*c*) In the event of the death, insolvency or bankruptcy of any administrative member or of any such attempted assignment or transfer of membership by any member, whether administrative, professional or beneficiary, or of any certificate evidencing the same, or of any interest of any administrative member in this corporation or in any of the property or assets thereof, whether by the voluntary act of the member or otherwise, such membership certificate, and, in the case of administrative membership, all interest of any such member in this corporation and in or to any of the property or assets thereof, shall be immediately canceled, revoked, and automatically terminated.

(*d*) Forfeiture or other termination of administrative, professional or beneficiary membership shall be governed by the by-laws and shall be as therein provided, except that the termination of membership for any reason shall forever and completely terminate any and all property and other interest of the member in this corporation or its assets and properties.

Seven: In the event of the dissolution of this corporation, all of its assets and property, after payment, satisfaction and discharge of all claims and demands against, and liabilities of the corporation, including claims of beneficiary members for the amount of dues then prepaid and unearned by the corporation, shall be distributed as follows: First, there shall be paid over and distributed to the professional members a sum equal to all assessments paid by them, and if the assets and property remaining are insufficient for a return in full to each professional member of all assessments, a pro rata distribution shall be made; second, any assets or property then remaining shall be paid over and distributed to the beneficiary members in proportion to the amount of dues contributed by each thereof.

Eight: Authority is hereby granted to the administrative members to change from time to time the authorized number of trustees of this corporation by duly adopted by-laws fixing or changing the number. By-laws may be adopted, amended or repealed by the trustees or by the vote or written assent of a majority of the administrative members.

Nine: These articles of incorporation may not be amended without the vote or written assent of two-thirds (2/3) of all of the administrative members.

In Witness Whereof, the undersigned, constituting the incorporators of the corporation, including the persons named hereinabove as the first trustees of the corporation, have executed these articles of incorporation this ——— day of January, 1939.

Signed:

Oliver D. Hamlin
George G. Reinle
Philip K. Gilman
Howard Morrow
Alson R. Kilgore
Karl L. Schaupp
T. Henshaw Kelly
Lowell S. Goin
Harry H. Wilson
John C. Ruddock
Carl R. Howson
Calvert L. Emmons
Louis A. Packard
Axcel E. Anderson
Dewey R. Powell
W. Earl Mitchell
Alfred L. Phillips
Samuel Ayres, Jr.
William H. Kiger
Charles A. Dukes
George H. Kress
William W. Roblee
S. J. McClendon
Ray Lyman Wilbur
C. Kelly Canelo
Henry S. Rogers
John W. Green
Junius B. Harris
Frederick N. Scatena

HOTEL RATES FOR DEL MONTE ANNUAL SESSION

The 1939 annual session of the California Medical Association will be held at Hotel Del Monte, commencing on Monday, May 1, and continuing through Thursday noon, May 4. In coöperation with the Hotel Del Monte, hotel rates have been secured as given in the list which follows. Requests for reservations may be sent to the Hotel Del Monte, or other hotels, direct.

(COPY)
Hotel Del Monte
Del Monte, California,
January 11, 1939.

Dr. George H. Kress
Secretary, California Medical Association
450 Sutter Street
San Francisco, California

Dear Doctor Kress:

As per your request with our Mr. Hubbard, we are enclosing herewith schedule of the various Peninsula hotel rates, compiled in connection with the annual session of the California Medical Association to be held at Del Monte, May 1–4, 1939.

You stated it was your wish to publish these rates in the next issue of the medical journal so that the doctors may refer to the same when making reservations for the period of the convention.

Thanking you for your coöperation in this matter, and with kindest regards, I am

Sincerely yours,
Natt Head,
Assistant Manager.

* * *

Hotel Del Monte, Del Monte

East Wing	*Per Day*
Single room without bath, one person	$7.50 each person
Double room without bath, two persons	7.00 each person
Single room with bath, one person	8.50 each person
Double room with bath, two persons	7.50 each person
Two single rooms, bath between, two persons	8.00 each person
Two double rooms, bath between, four persons	7.00 each person

Main Building, Cottages, and Remodeled West Wing

Single room with bath, one person	$9.50 each person
Double room with bath, two persons	8.50 each person
Sitting room	8.00

The above rates are based on the American Plan of service, which includes meals.

* * *

Del Monte Lodge, Pebble Beach

Located approximately five miles from the Hotel Del Monte, overlooking the ocean

Same management as Hotel Del Monte

Single room and bath	$9.50 per day per person
Double room and bath	8.50 per day per person
Sitting room	8.00 per day additional

American Plan, which includes meals.

Mission Inn, Monterey

Located in the heart of Monterey, one mile from Hotel Del Monte

10 rooms with double beds and bath	$3.00 single 4.00 double
5 rooms with twin beds and bath	5.00 double
6 rooms without bath	1.50 single 2.00 double
A few large suites accommodating from three to five persons	1.50 to 1.75 per person

* * *

Asilomar, Monterey Peninsula

Asilomar is located in Pacific Grove, about six miles from Hotel Del Monte

European Plan (without Meals)

	Persons	*Per Person*
16 double rooms, each with private bath and shower	32	$4.00
20 single rooms, each with connecting toilet and shower	20	3.00
10 double rooms, each with connecting toilet and shower	20	2.50
7 single rooms, each with connecting toilet	7	2.50
6 double rooms, each with connecting toilet	12	2.25
5 single rooms, running water—conveniences near by	5	2.25
30 double rooms, running water—conveniences near by	60	2.00
10 triple rooms, running water—conveniences near by	30	1.50

The above-mentioned accommodations are located in the Hill Top, Scripps, Lodge, and Guest Inn. These buildings are all heated, each has its own lounge and open fireplace, and all rooms, except four doubles in Scripps, have twin beds.

Meal Rates

Breakfast, 50 cents; lunch, 85 cents; dinner, $1.

* * *

Forest Hill Hotel, Pacific Grove

Located in Pacific Grove, approximately four miles from Del Monte—Situated in residential section of Pacific Grove

European Plan

Single room and bath	$2.50 per day
Double room and bath	4.00 per day
Double room and bath (twin beds)	5.00 per day

Dining Room

Breakfast, a la carte; luncheon, 65 cents; dinner, 85 cents and $1.

Garage, 35 cents per day.

* * *

Highland Inn, Carmel

Located four miles south of Carmel and seven miles from Del Monte

European Plan

Single room with bath	$4.00 and $4.50 per day
Double room with bath	5.00 and 6.00 per day

Meal Rates

Breakfast, 75 cents; luncheon, $1; dinner, $1.25

* * *

Hotel San Carlos, Monterey

Located in the heart of Monterey, one mile from Hotel Del Monte

European Plan

20 rooms with twin beds	$6.00 and $7.00 per day
45 rooms with double beds and tub bath	3.00 single 4.50 double
45 rooms with double beds and shower bath	2.50 single 3.50 double

* * *

La Playa Hotel, Carmel

Located in the heart of Carmel, and about five miles from Del Monte

European Plan

Single rooms—Lodging and breakfast, $4.00 to $6.00. Ocean view rooms starting at $5.00

Double rooms—Lodging and breakfast, $8.00 to $10.00. Ocean view rooms starting at $9.00

About forty of these rooms are equipped with twin beds, and ten with double beds.

Hotel La Ribera, Carmel

Located in Carmel, which is approximately five miles from Del Monte

7 twin-bedded rooms with bath	$5.00 per day
4 twin-bedded rooms without bath	3.50 and 4.00 per day
4 double rooms with bath (double beds)	3.00 single 4.00 double
4 double rooms without bath (double beds)	2.00 single 3.00 double
4 double rooms without bath (double beds)	2.00 single 3.00 double

* * *

Pine Inn, Carmel

Located in the heart of Carmel

	Per Day	
American Plan	*Single*	*Double*
Room with detached bath	$4.50	$7.00
Room with private bath	$5.00 to $6.00	$8.00, $9.00 $10.00, $12.00
European Plan		
Room with detached bath	$2.50	$3.00
Room with private bath	$3.00 to $5.00	$3.50 to $7.00

Cottages

American Plan, per person, per day	$4.00, $5.00, $6.00
European Plan per cottage, per day (depending on number of guests and choice of cottage)	$6,00 $8.00, $10.00, $12.50, $15.00

* * *

Hotel Monterey, Monterey

Small commercial hotel located in the heart of Monterey, one mile from Hotel Del Monte

European Plan

2 rooms with twin beds and bath	$4.00 double
4 suites (2 rooms, each with bath adjoining)—one double bed in each room	6.50—4 persons
1 suite (2 rooms, with one double bed in each, bath adjoining the two rooms)	6.50—4 persons
5 rooms with one double bed and bath at $2.50	3.00 double
7 rooms with one double bed and bath at $3.00	3.50 double
1 room with one double bed and shower at $2.50	3.00 double
20 rooms with one double bed, no bath, at $1.50	2.00 double

C. M. A. DEPARTMENT OF PUBLIC RELATIONS[†]

DOCTOR WILBUR HEAD OF NEW HEALTH PLAN

Dr. Morton R. Gibbons, Sr., San Francisco, Is Named Medical Director; Service Rates to Come Later

Seattle Study

Committee to Gather Data on Northern Organization; Speed to Be Sought in Operations

Dr. Ray Lyman Wilbur yesterday was elected president of the board of trustees which will regulate the new statewide health-insurance system.

In addition to being president of Stanford University, Doctor Wilbur is past president of the American Medical Association and former Secretary of the Interior.

The week-end meeting, officially designated as the first session of the board of trustees of the California Physicians' Service, appointed Dr. Morton R. Gibbons, Sr., of San Francisco as medical director for the system.

Aides Later

Doctor Gibbons' assistants will be named later by the Physicians' Service, through which the California Medical Association and its six thousand members will operate a system of medical and hospital insurance for persons of average means.

Also to be acted upon at further meetings of the trustees are the rates to be charged to subscribers, the maximum income groups to be eligible for membership, and the fees to be paid to doctors.

A committee was named to visit Seattle and study the "King County plan," which provides for medical care for approximately 35,000 workers in and around Seattle. The Seattle plan is similar to the California project.

With the report of this committee, plus other information now being gathered, the trustees will be enabled to decide on the type of service to be offered and its cost.

Facilities of the state's three nonprofit hospitalization insurance groups already in existence will be utilized to speed up operation of the medical association's system, the trustees said.

Groups Connected

These groups, which provide hospitalization only and not medical attention, are the Insurance Association of Approved Hospitals in the Bay Area, the Intercoast Service in Sacramento, and the Associated Hospital Service of Southern California.

Soon to be selected from a small group of candidates, according to the trustees, is a business manager for the service.

Present at yesterday's session, in addition to Doctor Wilbur and Doctor Gibbons were: Drs. C. Kelly Canelo of San Jose and Lowell S. Goin of Los Angeles, named vice-presidents; Dr. Alson R. Kilgore of San Francisco, elected secretary-treasurer; Dr. T. Henshaw Kelly of San Francisco, chosen assistant secretary-treasurer; Dr. W. E. Mitchell of Oakland, Dr. Samuel Ayres, Jr., of Los Angeles, and Hartley Peart and Howard Hassard, California Medical Association counsel.—*San Francisco Examiner*, January 30, 1939.

RECOMMENDATIONS OF THE AMERICAN PUBLIC HEALTH ASSOCIATION TO THE TECHNICAL COMMITTEE ON MEDICAL CARE[*]

1. It is certainly theoretically desirable that a single state agency should be made administratively responsible for carrying out all the provisions of the national health program which may be enacted into law.

In recommending that this single agency should be the state department of health, we recognize that the present patterns in most states do not conform to this proposal, yet we note evidence that organized medicine and many public welfare officials share our opinion that at least ultimately the state health department should be the responsible agency. We believe that there are many affirmative reasons why the state health department is the best agency at the state level for this purpose. No agency will be able so readily or effectively as the health department to provide professionally qualified personnel and be so readily or effectively able to maintain high professional standards of medical care.

In recommending that the state health department should be the primary integrating and coördinating unit, we recognize that the counsel of qualified advisers from the medical, dental, nursing, hospital and ancillary professions will be requisite, that adequate provisions for technical staffs and administrative expense will have to be made from the outset, and that increased funds for training purposes will be essential for successful performance. We have concluded further that, however reluctant medical health officers may be at present to take over these added responsibilities, a study of the alternative choices for such purposes will be determinative. This basic recommendation does not preclude a working arrangement in some states with existing machinery outside of the official health department which might function well through another channel, provided that the state health officer retains supervisory control over the broad plans and the general purposes of the funds which the state may receive. It is further recommended that in such plans due consideration will be given to the allocation of funds by a state department of health to the various substantial governmental jurisdictions within a state where population, extent of the special problems or financial need justify.

[†] The complete roster of the Committee on Public Relations is printed on page 2 of the front advertising section of each issue. Dr. George G. Reinle of Oakland is the chairman and Dr. George H. Kress is the secretary. Component county societies and California Medical Association members are invited to present their problems to the committee. All communications should be sent to the director of the department, Dr. George H. Kress, Room 2004, Four Fifty Sutter Street, San Francisco.

[*] The "Technical Committee on Medical Care" is a group consisting largely of lay members, who were appointed in 1935 by President Roosevelt's "Interdepartmental Committee" to bring in a report to the latter committee, subsequently submitted at the National Health Conference in July, 1938.

We note that this proposal is in accord with the recommendation of the Interdepartmental Committee that this program should be developed around and be based upon existing preventive health services.

2. The Committee reaffirms and reëmphasizes the official declaration of the American Public Health Association that, in the initiation and development of the program, wide latitude should be given to the states in the definition of the population to be served, in the selection of the method of providing medical service, and in other important phases of the proposed program. We believe that similar latitude should be provided with regard to the method of raising funds in the states to accomplish approved objectives.

3. The Committee finds itself in agreement with the recommendations in the national health program that the fundamental objectives involved here are, first, conservation of health and vitality and, second, reduction of the rôle of sickness as a cause of poverty and dependency. With this in mind, it supports the concept that Recommendations 1, 2, and 3 of the Interdepartmental Committee (the expansion of public health and maternal and child health services, the expansion of hospital, clinic and other institutional facilities, and the provision of medical care for the medically needy) should have priority in initiation.

4. We believe that recent experience demonstrates that the Social Security Act provisions for aid to the states for health work provide a suitable framework for the expansion of preventive health services.

5. We submit that it is essential that any state program to be approved for federal aid should contain adequate provisions for the maintenance of high personnel standards and that payment of such federal aid to state agencies should be withheld when it is found that substandard services are being furnished. Similar policy should obtain with respect to state aid to local areas within a state. The appropriate federal administrative authorities should have power to establish minimum standards through rule and regulation after consultation with competent advisory professional bodies.

6. Careful study will be necessary to perfect administrative regulations to cover the details concerned with the provision of medical services, so as to assure a high level of quality. We believe that standards of medical practice should not be written into basic law. Federal aid should be conditioned on inclusion within the state plans of adequate safeguards for maintaining appropriate standards.

7. We believe that the extension and improvement of public-health services in general throughout the country requires complete integration of health services of the Federal Government under one cabinet officer, preferably a Secretary of Health.

PRESIDENT ROOSEVELT MAY SUBMIT HEALTH PROGRAM TODAY

Message Expected Asking Congress for Huge Appropriation to Finance Plan

Washington, January 22 (AP).—President Roosevelt is expected to urge Congress, in a special message tomorrow, to enact legislation for a huge, long-range health-improvement program.

The health program, which would provide for expenditures of up to $850,000,000 annually from state and federal funds by 1949, has been a controversial issue since it was recommended to Mr. Roosevelt last July by his special Interdepartmental Committee of Health and Welfare.

It will go to a Congress already showing signs of economy-mindedness and embroiled at present in dispute over how much should be appropriated to run WPA for the next five months.

Meets New Setback

President Roosevelt suffered his second setback on the relief issues yesterday when the Senate Appropriations Committee aproved a $725,000,000 appropriation, the same amount voted by the House. The Chief Executive had asked $875,000,000.

Despite the committee's action, Administration leaders said they had hopes the Senate would vote the amount asked by the President. In that case the actual appropriation probably would be determined by a compromise committee of Senators and House members.

Recovery Peril Seen

Senator Wagner (Democrat), New York, asserted the bill as reported out "would do more than bring misery and privation to millions of American citizens—it would seriously threaten our entire recovery movement."

Abandonment of the relief and recovery program voted by the last Congress to stem the business recession which began in 1937, Wagner said in a statement, "would be a form of national economic suicide."

He said the relief sum asked by the President contemplated a net reduction of 400,000 in WPA employment by June and was "based on the most optimistic estimates of business revival."

Close Vote Expected

The estimate assumed, Wagner added, that private industry would absorb 1,500,000 of the present unemployed in the next five months.

Both Administration leaders and advocates of the lower figure conceded that the vote in the Senate would be close. One Administration supporter said there probably was a majority at present for the $725,000,000, but predicted several votes would shift to support of the President's recommendation.

Hopkins Vote Due

Mr. Roosevelt will have opportunity to discuss strategy in the floor fight for the higher figure when he has his regular weekly meeting tomorrow with his legislative lieutenants.

Senate debate on the relief appropriation may begin later in the day. Majority Leader Barkley (Democrat), Kentucky, said it would be taken up immediately after a vote on confirmation of Harry Hopkins' nomination to be Secretary of Commerce. An affirmative vote is expected tomorrow; even those who said they would vote against confirmation conceded there was no chance that the nomination would be rejected.

Senate and House committees will hear war and navy officials this week on President Roosevelt's defense recommendations. Hearings will start on railroad legislation.

Wagner Drafts Bill

Senator Wagner has prepared a bill calling for a $50,000,000 appropriation to begin the proposed health program.

While the proposal stirred up some opposition in medical circles, the American Medical Association agreed last September with the Interdepartmental Committee that there was a vital need for an extension of existing medical facilities.

Money appropriated for the health program would, according to recommendations of the committee, be used to:

1. Pay physicians to care for those too poor to afford medical care.
2. Assist existing hospitals and build new ones where needed, particularly in rural areas.
3. Establish clinics for quick diagnosis and treatment of disease.
4. Encourage vaccination against preventable diseases.
5. Develop maternal and child welfare facilities, including baby clinics, schools for expectant mothers, visiting nurses, and obstetrical care if needed.
6. Stimulate public health service to control disease through such activities as controlling stream pollution, establishing more efficient quarantines, health instruction for both children and adults and closer inspection of milk and water supplies.

Funds would be allotted to states and communities under restrictions requiring that they do their part in health promotion.—Los Angeles *Times*.

TEXT OF ROOSEVELT MESSAGE URGING UNITED STATES HEALTH PROGRAM

Washington, January 23 (AP).—The text of President Roosevelt's message to Congress today proposing a national health program follows:

In my annual message to the Congress I referred to problems of health security. I take occasion now to bring this subject specifically to your attention in transmitting the report and recommendations on national health prepared by the Interdepartmental Committee to coördinate health and welfare activities.

The health of the people is a public concern; ill health is a major cause of suffering, economic loss, and dependency; good health is essential to the security and progress of the nation.

Health needs were studied by the Committee on Economic Security, which I appointed in 1934, and certain basic steps were taken by the Congress in the Social Security Act. It was recognized at that time that a comprehensive health program was required as an essential link in our national defenses against individual and social insecurity. Further study, however, seemed necessary at that time to determine ways and means of providing this protection most effectively.

Tells Finding of Nation-Wide Group

In August, 1935, after the passage of the Social Security Act, I appointed the Interdepartmental Committee to coordinate health and welfare activities. Early in 1938 this committee forwarded to me reports prepared by their technical experts. They had reviewed unmet health needs, pointing to the desirability of a national health program, and they submitted the outlines of such a program. These reports were impressive. I, therefore, suggested that a conference be held to bring the findings before representatives of the general public and of the medical, public health, and allied professions.

More than two hundred men and women, representing many walks of life and many parts of our country, came together in Washington last July to consider the technical committee's findings and recommendations and to offer further proposals. There was agreement on two basic points: the existence of serious unmet needs for medical service, and our failure to make full application of the growing powers of medical science to prevent or control disease and disability.

Declares Some Parts of Country Handicapped

I have been concerned by the evidence of inequalities that exist among the states as to personnel and facilities for health services. There are equally serious inequalities of resources, medical facilities and services in different sections and among different economic groups. These inequalities create handicaps for the parts of our country and the groups of our people which most sorely need the benefits of modern medical science.

The objective of a national health program is to make available in all parts of our country and for all groups of our people the scientific knowledge and skill at our command to prevent and care for sickness and disability; to safeguard mothers, infants, and children; and to offset, through social insurance, the loss of earnings among workers who are temporarily or permanently disabled.

The committee does not propose a great expansion of federal health services. It recommends that plans be worked out and administered by states and localities with the assistance of federal grants-in-aid. The aim is a flexible program. The committee points out that, while the eventual costs of the proposed program would be considerable, they represent a sound investment which can be expected to wipe out, in the long run, certain costs now borne in the form of relief.

Recommends Careful Study by Congress

We have reason to derive great satisfaction from the increase in the average length of life in our country and from the improvement in the average levels of health and well-being. Yet these improvements in the averages are cold comfort to the millions of our people whose security in health and survival is still as limited as was that of the nation as a whole fifty years ago.

The average level of health or the average cost of sickness has little meaning for those who now must meet personal catastrophes. To know that a stream is four feet deep on the average is of little help to those who drown in the places where it is ten feet deep. The recommendations of the committee offer a program to bridge that stream by reducing the risks of needless suffering and death, and of costs and dependency, that now overwhelm millions of individual families and sap the resources of the nation.

I recommend the report of the Interdepartmental Committee for careful study by the Congress. The essence of the program recommended by the committee is federal-state coöperation. Federal legislation necessarily precedes, for it indicates the assistance which may be made available to the states in a coöperative program for the nation's health.—Los Angeles *Herald-Express*.

CANCER COMMISSION OF THE CALIFORNIA MEDICAL ASSOCIATION

I. X-Ray Conference

The annual Radiological Conference, sponsored by the Cancer Commission, will take place at Del Monte, Sunday, April 30, 1939, in connection with the State meeting. The morning program will consist of diagnostic problems beginning at 10 o'clock, and the afternoon, of therapeutic problems, beginning at 1:30 o'clock. The chairman of the committee arranging this meeting, who will have charge, is Dr. L. H. Garland. If you have a problem for discussion, bring it along with films and slides. It would be advisable to have extra films, so that they could be viewed on extra boxes at close range.

Kindly inform if you have a problem, and make reservations with Chairman L. H. Garland at 450 Sutter Street, San Francisco, or with the Secretary of the Cancer Commission, Dr. Otto H. Pflueger, 384 Post Street, San Francisco.

II. Cancer Commission General Meeting

The first meeting for general surgeons and general practitioners, sponsored by the Cancer Commission of the California Medical Association, will take place in Del Monte, Sunday, April 30, 1939, in connection with the State meeting. The program, which is to begin at 10 a. m., will consist of malignant tumors of the skin, being presented in the morning, and tumors of the breast comprising the afternoon program. Clinical material will be presented together with microscopic slides of cases under discussion. It will be necessary, therefore, that you bring a microscope if you plan to attend.

In the past many non-specialists have attended the other meetings sponsored by the Cancer Commission, and it is for these persons that this meeting is being arranged. We are sure that it will be an interesting meeting and very worth while.

Accommodations must be limited for the greatest benefit to those attending, and it will be necessary, therefore, that reservations be made with the secretary of the Cancer Commission, Dr. Otto H. Pflueger, 384 Post Street, San Francisco.

Please let us stress the need for making early reservations and the necessity of each attendant bringing a microscope.

* * *

III. Cancer Commission Pathological Conference

The next Microscopic Conference, sponsored by the Cancer Commission of the California Medical Association, will be held in connection with the State meeting on Sunday, April 30, 1939, at 9:30 a. m. The committee in charge of this conference consists of Drs. Paul Michael (chairman), Jesse Carr, and Alvin Cox. If you have a case which you would like to present, send in two or three sample slides and a case history for the committee's approval. If a case is accepted, the committee will notify you and ask that you make up a set of sixty slides for distribution. The committee is particularly anxious to obtain slides which are made of properly fixed material, so that the slides will be satisfactory for diagnosis.

We are particularly interested in getting the cases ready several weeks before the meeting, and would appreciate receiving sample slides and histories as early as possible. We feel that if slides can be sent to the pathologists throughout the state at least two weeks before the meeting, the cases can be diagnosed more satisfactorily and the discussion will be much more interesting.

Will you kindly give this matter your prompt attention, in order that we may make the program as interesting as possible. Kindly send your preliminary histories and slides to the chairman of the committee, Dr. Paul Michael, 434 Thirtieth Avenue, Oakland. He will get in touch with you concerning the cutting of sixty sections if your cases are accepted.

Bring your own microscope and make reservations with the chairman of the committee, or with the secretary of the Cancer Commission, Dr. Otto H. Pflueger, 384 Post Street, San Francisco.

PROPOSED MEDICAL LEGISLATION

Submitted to 1939 California Legislature

Bills Introduced Prior to January 27, 1939:

S. (Senate) 130 and A. (Assembly) 493 propose to require a physician or other person attending a pregnant woman to obtain or cause to be obtained a blood specimen at or within ten days after his first professional visit. The blood specimen thus obtained must be submitted to an approved laboratory for a standard laboratory test for syphilis.

S. 144, A. 490 and A. 492, to amend the laws relating to vital statistics, propose that a certificate of birth include, in addition to the information now required by law, the following item: "Prenatal examination for syphilis, including period of gestation in months or weeks at which examination was made, and if examination was not made, including reason for not making such examination."

S. 173 and A. 106 propose as a condition precedent to the issuance of licenses to marry that each party to a prospective marriage present a physician's certificate that he or she "has been given such examination, including a standard serological test, as may be necessary for the discovery of syphilis, made not more than thirty days prior to the" application, "and that in the opinion of the physician the person either is not infected with syphilis, or if so infected, is not in a stage of that disease which is or may become communicable to the marital partner."

A. 235 proposes to exempt from the Use Tax Act of 1935 "The storage, use or other consumption in this state of orthopedic supplies."

A. 236 proposes to exempt from the Retail Sales Tax Act of 1933 "the gross receipts from sales of orthopedic supplies."

A. 342 proposes to prohibit the issuance of a license to marry unless both parties to the prospective marriage file a certificate made by a physician within ten days of the application showing that both parties are free from any contagious, infectious or communicable disease.

A. 437, to supplement the Business and Professions Code, proposes to make it a misdemeanor for any person who does not possess a physicians and surgeons' certificate or a drugless practitioner's certificate to use in any sign or advertisement the term "drugless physician, drugless methods, naturopath, naturopathic physician, sanipractor, masseur, physiotherapist, physical-therapist, diet specialist or health adviser or who uses any degree or the abbreviation relating to or standing for all or any of the foregoing terms."

A. 438, to supplement provisions of the Business and Professions Code relating to the practice of medicine, proposes that "The fraudulent representation by advertisement or otherwise that a manifestly incurable condition or sickness, disease, deformity, ailment, or injury of any person can be cured constitutes unprofessional conduct within the meaning of this chapter."

A. 449 proposes that on and after July 1, 1940, every applicant for a physicians and surgeons' or drugless practitioner's certificate, or for a certificate to practice chiropody or midwifery must be a citizen of the United States.

A. 450 proposes to make the sale, dispensing, or prescribing of dinitrophenol for therapeutic purposes a misdemeanor.

A. 477, to supplement the Business and Professions Code, proposes that unless a person holds a physicians and surgeons' certificate, or is licensed or authorized to use the title "doctor" or the letters or prefix "Dr.," the use of the title or letters or prefix without further indicating the type of certificate held, constitutes unprofessional conduct.

A. 469, to supplement the Business and Professions Code, proposes to make it unprofessional conduct, within the meaning of the chapter relating to medicine, for a licentiate knowingly to make or sign any certificate or other document required by law which falsely represents the existence or nonexistence of a state of facts.

A. 478, to amend the Business and Professions Code, proposes that the drugless practitioner's certificate provided for by the code, in addition to the authority it now confers, shall also authorize "the general and local application or use of any and all mechanical, manipulative, electrotherapeutical, hydrotherapeutical, dietary and psychological methods of treating the sick or afflicted for any purpose, including physiotherapy, physical therapy, colonic therapy, all methods of massage, baths, and any and all other types of drugless methods of treatment for the sick and afflicted."

A. 484 proposes to authorize courts, on the application of the people, the Board of Medical Examiners or the Board of Osteopathic Examiners, to restrain the unlicensed practice of medicine or osteopathy.

COMPONENT COUNTY MEDICAL SOCIETIES

KERN COUNTY

The Kern County Medical Society met at the Mercy Hospital in Bakersfield on Thursday evening, January 19. Dr. Chester Mead presided.

The new officers for 1939 are: Chester Mead, president; A. R. Moodie, vice-president; C. S. Compton, secretary. Harry Lange was elected to the Board of Directors. New delegates are: F. T. Gundry and C. S. Compton, with H. W. Jones and John McCarthy as alternates.

Two new members were welcomed into the Society: Dr. J. E. Vaughan and Dr. C. B. Stockton, both of Bakersfield.

Dr. L. A. Packard reported on the latest developments concerning the California Physicians' Service. The report was received with great interest by the members, who have pledged support of the proposed program.

Members were requested to submit topics for discussion at the postgraduate study course to be given this year.

Dr. Roderick A. Ogden introduced the speaker of the evening, Dr. James C. Negley of Glendale. Doctor Negley presented a statistical study on the *Modern Treatment of Bladder-Neck Obstructions,* based on observations in five private and charity hospitals in Los Angeles up to 1935. He reviewed instruments designed to relieve obstructions. His conclusions were that the operation of resection is now being used mainly by well-trained physicians and that the belief that resection is a minor procedure is waning. Also that prostatectomy is much the safer procedure for the majority of surgeons and that patients for resection need the same careful preoperative preparation as patients for prostatectomy. He also pointed out that many patients who have had resections continue to have symptoms following operation.

The meeting was then adjourned, following which light refreshments were served.

C. S. Compton, *Secretary.*

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MENDOCINO-LAKE COUNTY

The meeting of the Mendocino-Lake County Medical Society was held in the auditorium of the State Hospital at Talmage on December 10, 1938. In the absence of the president, Doctor Craig, the meeting was called to order by the secretary, Doctor Smalley. Doctor Cushman was asked to preside.

In addition to the members present, the Society had as guest speakers, Dr. George H. Kress, Secretary of the California Medical Association, and Dr. William Shepard. Secretary of the California Medical Association Pneumonic Control Committee.

The scientific aspect of pneumonia control with specific serum was discussed by Doctor Shepard, followed by a sound film on the same subject. Doctor Kress discussed the California Medical Association's plans for a state-wide medical service.

The following officers were nominated for the coming year: R. B. Smalley, president; Royal Scudder, vice-president; and Dallas Wagner, secretary-treasurer.

No other nominations being made, these candidates were unanimously elected.

For the office of delegate, Dr. Ruggles Cushman was unanimously elected; and for alternate, Dr. G. I. Barcklow.

A resolution of thanks to Doctors Kress and Shepard was unanimously adopted.

Likewise a resolution thanking Doctor Cushman for his cordial hospitality.

Robert B. Smalley, *Secretary.*

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PLACER COUNTY

The Placer County Medical Society held its meeting on January 21 at the Freeman Hotel, Auburn, with the president, William M. Miller, presiding. In addition to President Miller, there were present the following members and visitors:

Members—Doctors P. D. Barnes, Casey, Dubin, Dunievitz, Empey, Eveleth, Hummelt, Kindopp, Lewis, Lundegaard, Padgett, Peers, Rood, and Weddle.

Visitors—Dr. George M. Uhl, Chief of the Bureau of County Health Work of the State Department of Public Health, and Miss Lu Crandall, school nurse.

Following the reading of the minutes, President Miller stated that the order of business would be suspended so that Doctor Uhl and Miss Crandall might address the Society.

Doctor Uhl presented to the Society *a proposed plan for a full-time public health unit for a district,* comprising Placer, Nevada, and El Dorado counties, and asked the endorsement of this project. After full discussion of the matter, the county society endorsed the project.

The county society also endorsed a project presented by Miss Crandall for a *county-wide immunization against smallpox.*

The application of Dr. George A. Foster of Grass Valley for transfer from the Sacramento Society for Medical Improvement to the Placer County Medical Society, was read and, on motion of Doctor Peers, seconded by Doctor Empey, Doctor Foster was unanimously elected to membership.

The Secretary-Treasurer read a supplemental treasurer's report, showing that the cost of the advertising campaign against Proposition No. 2 on the November ballot was $149.30, and giving a statement of the present funds on hand.

Following the reading of correspondence and other routine business, Doctor Empey reported on the recent meeting of the special session of the House of Delegates held in Los Angeles in December. Doctor Empey's report brought out considerable discussion.

Robert A. Peers, *Secretary.*

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SAN JOAQUIN COUNTY

The regular meeting of the San Joaquin County Medical Society was held on January 5 on the roof garden of the Hotel Wolf. The meeting was called to order at 7:30 p. m. In the absence of the president, A. C. Boehmer, the meeting was called to order by the secretary, G. H. Rohrbacher, who introduced and turned the meeting over to President-elect Neill P. Johnson. Doctor Johnson told the Society his aim for the year, and named his committees for the year 1939.

Applications of Louis B. Saslaw and E. L. Blackmun, Jr., were presented and referred to the Admissions Committee. A communication from the Woman's Auxiliary to the San Joaquin County Medical Society was read, in which was enclosed a check for $1.46, being the amount returned to us after deduction from the $25 advanced to them. In their letter the Woman's Auxiliary stated that they had spent $23.54 in helping to defeat Proposition No. 2. Dr. Dewey Powell made a motion, seconded from the floor, that the check be returned to the Woman's Auxiliary for inclusion in their treasury. Doctor Powell read a eulogy on the passing of our late member, Dr. S. W. R. Langdon.

Doctor Broaddus spoke on the Postgraduate Committee, and presented certificates to several elected members of the Medical Academy of Graduate Study.

Dr. A. E. Anderson of Fresno, Councilor for the Fourth District, was introduced by President Neill P. Johnson. Doctor Anderson talked on the recent Del Monte meeting, at which time the prepayment of medical services was discussed. Doctor Anderson introduced President W. W. Roblee of the California Medical Association, who gave a very interesting talk on *the effort that had been made over a period of years by the California Medical Association to get the medical payment plan in that large group in the frankly indigent and the well-to-do classes.* He also touched on the aspect of socialized medicine from the federal viewpoint. Doctor Roblee then introduced Doctor George H. Kress, Secretary of the California Medical Association, who elaborated on the remarks of the two previous speakers.

Dr. Charles Sears, President of the Northwestern Medical Association and of the Oregon Medical Society, was present as a guest and was called upon by the Chair for any remarks that he might like to make. Doctor Sears stated that he was there to hear rather than to talk, but told briefly of plans in Oregon for handling a similar situation.

Mr. Harvey Van Vlear, Secretary of the San Joaquin County Farm Bureau, was present as a guest of the Medical Society and was called upon by the Chair for any remarks that he would like to make. Mr. Van Vlear spoke on the desire for coöperation between the Farm Bureau group and the Medical Society group, and stated that they were unalterably opposed to any compulsory medical service controlled by the state.

Dr. Dewey Powell, Frank Doughty, and C. A. Broaddus, delegates to the recent meeting at Los Angeles, told their reactions to this meeting and elaborated on the remarks of the other speakers.

There being no further business to come before the Society the meeting was declared adjourned at 11:15 p. m.

G. H. Rohrbacher, *Secretary.*

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SAN MATEO COUNTY

The meeting of the San Mateo County Medical Society was held on Wednesday evening, December 28, 1938, in the main dining room of the Benjamin Franklin Hotel. Doctor Hartzell Ray presided.

The meeting was well attended by members of the Society and their wives.

Doctor Ray announced that officers had been nominated at the previous meeting and that there had been no further nominations, and upon motion duly made, seconded and unanimously carried, the officers previously nominated were declared elected. The new officers are as follows: N. D. Morrison, president; Carl Benninghoven, vice-president; J. Garwood Bridgman, secretary; and Harper Peddicord, member of the board of directors.

Doctor Ray gave a report on the special meeting of the House of Delegates at Los Angeles, in which report he included the report of the Council to the House and the tentative draft concerning rules and regulations concerning hospitalization and medical care to be provided by the newly formed California Physicians' Service. The Secretary discussed the proposed plan and reported on the fourteen resolutions which were acted upon by the House of Delegates at the special meeting. The Secretary then introduced Dr. Alson A. Kilgore of San Francisco, who gave a very enlightening résumé of the situation and discussed the plan at some length, giving special attention to the factors underlying the decision of the Council to submit the proposed plan to a special session of the House of Delegates. Following Doctor Kilgore's discussion, he generously answered questions raised from the floor.

J. Garwood Bridgman, *Secretary.*

TULARE COUNTY

The Tulare County Medical Society held its regular meeting at the Hotel Johnson in Visalia on January 9 at 7 p. m. Dinner preceded the business meeting.

Dr. Elmo Zumwalt called the meeting to order at 8:20 o'clock.

A series of applications for membership to the Tulare County Medical Society was heard from Robert S. Hardin, Ellis Z. Sox, Fred Glenn De Busk, all of Visalia; Wiley Carl Zink and William Stanliey Ireton of Tulare. A short biography of each was read and, their applications having been passed on by the Board of Censors, they were unanimously elected to membership.

The new forms for the Emergency Relief Administration of the State of California for medical relief were shown to the members and a general discussion of matters pertaining to state relief administration medical attention followed. At the conclusion of the discussion, Doctor Zumwalt appointed Doctors Guido (chairman), Betts, and Ambrose to prepare recommendations from the Tulare County Medical Society regarding the schedule and other important state relief administration matters. A copy of their report is to be transmitted to the secretary before transmittal to the state relief administration officers.

A brief review of the voluntary staffing of the Tulare County Hospital agreement with the Board of Supervisors was next presented to the members for a decision at this time as to the future continuance of this service. There was a general discussion from the floor with various suggestions and a final motion by Dr. J. C. McClure, seconded by Dr. W. Zink, as follows:

It is moved and seconded that the Tulare County Medical Society appoint those men at present acting on the voluntary staff at the Tulare County Hospital and those wishing to act in the future, as a committee to organize and operate the Tulare County Hospital as they see fit. This group is then to report to the Tulare County Medical Society, who will subsequently communicate the plans to the Tulare County Board of Supervisors for their approval.

Dr. Ellis Scott, Tulare County Health Officer, presented a communicable disease chart and reported on the conditions of the county, generally, since his administration took over.

Election of officers for the year 1939 resulted in a unanimous ballot being cast for the following: Newton Miller of Porterville, president; Palmer D. Miller of Dinuba, vice-president; Ray E. Cronemiller, secretary-treasurer; S. S. Ginsburg (1942), Ray Rosson (1940), and A. W. Preston (1939), censors.

Delegates to the State convention: Elmo R. Zumwalt of Tulare; alternate, Newton Miller of Porterville.

Doctor Zumwalt concluded the meeting with a word of appreciation for the coöperation extended him during the past year.

Karl F. Weiss, *Secretary.*

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VENTURA COUNTY

The regular monthly meeting of the Ventura County Medical Society was held at the Saticoy Country Club on Tuesday, January 10.

Doctor Mosher introduced Dr. Elmer Belt of Los Angeles, who gave a very interesting and instructive talk on *Gonorrhea and Its Complications.* Doctor Belt introduced Doctor Folkenberg of Los Angeles, who discussed the *Treatment of Gonorrhea by Sulfanilamid and Heat;* he also presented the latest methods for culturing the organisms.

The following communications were read: (1) From the Committee on Scientific Work regarding a booth devoted to plans and photographs of modern offices of physicians. (2) From the State Medical Library, Los Angeles Division, in regard to journals available. (3) From the Los

Angeles Society of Ophthalmology and Otolaryngology regarding a proposed legislative bill to license and regulate dispensing opticians.

Doctor Smolt moved that the Society endorse a bill to license and regulate dispensing opticians in the State of California, and that the secretary of the California Medical Association be informed by letter. The motion was seconded by Doctor Coffey and was unanimously carried.

Doctor Shore moved that the Society request the Council of the California Medical Association to set up a unit of the California Physicians' Service in this district as soon as expedient. Seconded by Doctor Strong. Carried.

Doctor Shore moved that Doctor Packard of Bakersfield be named to the Board of Directors of the California Physicians' Service. Seconded by Doctor Smolt. Unanimously carried.

A. A. Morrison, *Secretary.*

CHANGES IN MEMBERSHIP

New Members (5)

Alameda County

C. L. Freytag

San Francisco County

Benton D. Mathews
Gerald P. O'Hara
John M. Moore

Shasta County

Evan G. Gamette

Transferred (2)

Mark L. Gerstle, Jr., from San Francisco County to New York State.

Frederick C. Warnshuis, from San Francisco County to Massachusetts State.

In Memoriam

Bishop, Thomas W. Died at South Pasadena, December 28, 1938, age 68. Graduate of Bellevue Hospital Medical College, New York, 1895, and licensed in California the same year. Doctor Bishop was a member of the Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

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Hobdy, William Cott. Died at San Francisco, December 26, 1938, age 68. Graduate of Columbia University College of Physicians and Surgeons, New York, 1896. Licensed in California in 1920. Doctor Hobdy was a member of the San Francisco County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

✣

Langdon, Samuel Walter Ross. Died at Stockton, December 29, 1938, age 65. Graduate of the University of California Medical School, San Francisco, 1900, and licensed in Californa the same year. Doctor Langdon was a member of the San Joaquin County Medical Society, the California Medical Association, and the American Medical Association.

✣

Taltavall, William Allan. Died at Redlands, December 22, 1938, age 79. Graduate of Columbia University College of Physicians and Surgeons, New York, 1885. Licensed in California in 1903. Doctor Taltavall was a member of the San Bernardino County Medical Society, the California Medical Association, and the American Association.

OBITUARIES

William C. Hobdy

1870–1938

At the age of sixty-eight years, with a most commendable medical record behind him, Dr. William C. Hobdy recently passed away. He was a member of the San Francisco County Medical Society since 1921, having come here the year previously from Hawaii. Doctor Hobdy was a Kentuckian by birth and education, graduating from the University of Kentucky, where he was the outstanding athlete and honor man. Later, at the Columbia University Medical School he found time to be a member of the Columbia crew. After two years as house officer there, he joined the United States Public Health Service and was sent to the Hawaiian Islands. The character of his work there resulted in his being ordered to San Francisco at the time of our serious plague in 1906. With his family, he arrived here six weeks before our earthquake, safe in his residence at Angel Island. He was Port quarantine officer during the plague, while Dr. Rupert Blue was in charge of the city. Among his many responsibilities was the difficult feat of completely disinfecting twelve large ships a day average for a year.

He then returned to the Hawaiian Islands and continued only briefly his public health work, returning from that into extensive general surgery. He was on the teaching staff of Stanford University and Franklin Hospital. He reached the heights of the Masonic order, and for some years was noted for his interest in big game hunting.

His widow and daughter and son have been extended our sympathy in the loss of a valued member with a brilliant career behind him.

H. M. F. Behneman, M. D.

✣

Samuel Walter Ross Langdon

1873–1938

The members of the San Joaquin County Medical Society were shocked and grieved to learn of the sudden passing on December 30, 1938, of their esteemed and respected fellow member, Dr. Samuel Walter Ross Langdon.

Doctor Langdon was born in the city of Stockton on September 12, 1873. His family was prominently identified with the pioneer days of California, and he was a direct descendant of Reverend Samuel Langdon, president of Harvard during the Revolutionary War. His two uncles, Dr. Samuel Langdon and Paul Langdon, came to California in 1847. Paul was one of the first commandants of Mare Island Navy Yard, and Doctor Samuel, after serving there for a period in a professional capacity, came to Stockton and was on the State Hospital staff from 1856 to 1857.

Samuel W. R. Langdon, Jr., entered Harvard in 1893 and received an A. B. degree in 1897. He entered the University of California Medical School in 1897 and received an M. D. degree from that institution in 1900. He interned a year at the French Hospital in San Francisco, and then served a year on the Emergency Hospital staff in that city. He began the practice of medicine in the city of Stockton in 1902, and for eight years he was health officer of the city of Stockton. He served for six years as superintendent of Clark's Sanitarium, a private sanitarium for nervous and mental diseases. In 1908, during the bubonic plague in California, he was one of the committee of five appointed in the eradication of plague in the state. In 1909 he was president of the Central California Health Association, and in 1910 president of the San Joaquin Valley Medical Society.

During 1902 and 1912, Doctor Langdon was also active in the civic, political, and church life of the community. In 1920 he disposed of his interests, in which he had been quite successful, and, freed from business responsibilities, he spent the next several years, 1922 to 1925, in traveling with his family about the world. From 1925 to 1930, inclusive, he lived in Oakland, retired, merely supervising his various interests. In 1931 he joined the staff of the Stockton State Hospital, in which capacity he was still active up to the time of his death.

To those of us who had the privilege of knowing Doctor Langdon through the years there will always remain the vivid impression of the kindly gentleman. He manifested those many qualities of courtesy and consideration so characteristic of the Old South, whence his ancestors came to this far western country, and his greatest delight was in sharing with his friends the hospitality of his home.

The members of this society extend to his widow, son and daughter, their most sincere sympathy in their great loss.

Dewey R. Powell, M. D.

Donald Maclean
1872–1939

The people of the State of Nevada came to mourn the loss of one of their most beloved citizens, and the medical profession of the state one of its most prominent surgeons, in the passing on the fourth day of January of Dr. Donald Maclean.

Doctor Maclean was the only son of the late Dr. Donald Maclean, former professor of surgery at the Ann Arbor Medical School. After attending the schools in Detroit, Michigan, he was sent by his father to the University of Edinburgh, where he received the degree of M. D. in 1898. Upon his return to this country he enlisted in the army during the Spanish-American War and was sent to the Hawaiian Islands, where he served until the end of the war. In 1903 he was associated with Dr. Maurice Kahn at the Leadville, Colorado, mines, later to be relieved by Doctor Connell. He came to the State of Nevada in 1905 and has been a resident of this state ever since, having attained through his genial disposition, his incomparable frankness, thorough understanding, keen surgical judgment, and ability, a host of friends over the entire state. Doctor Maclean was always very active in the political life of the state, and served as chief medical adviser to the Nevada Industrial Commission in the years 1913 to 1927. He held many other appointments during his life, such as surgeon to the Orphans' Home; surgeon to the Nevada State Penitentiary in the years 1910 to 1923; chief of staff at Saint Mary's Hospital for two consecutive terms; past president of the Washoe County Medical Society; and up until the time of his death, a member of the Board of Hospital Trustees of the Washoe General Hospital. He was a member of the Nevada State Medical Association, the American Medical Association, and a Fellow of the American College of Surgeons.

Doctor Maclean had been in failing health for the past four months, and was stricken with coronary thrombosis at his desk in the sixty-sixth year of his life. In his passing we have lost one of our most beloved surgeons. For a long time to come his kindly personality will be missed by the scores of friends and patients to whom he has always been a guiding spirit.

Vinton A. Muller.

Henry Corbin McClenahan
1871–1939

At the age of sixty-eight years, the San Francisco County Medical Society lost one of its oldest members in the death of Doctor McClenahan. He was born in Georgia, and received his medical education at Tulane University. Coming to California in 1903, he was intimately connected with Belmont Sanitarium for some years. He then went abroad to study, later returning to San Francisco. Doctor McClenahan led a very active life, practicing before coming here, first in Texas, and then as the surgeon in charge of Roosevelt's famous "Rough Riders" in Cuba. He obtained the rank of captain in the Spanish-American War. He was an avid hunter, being at one time champion of the southern United States in pigeon shooting.

He published quite a bit in his specialty of psychiatry and neurology, and was on the staff of Cooper, later Stanford Medical School. Doctor McClenahan never was in general practice, but confined his work to the field of neurology, in which he was for some years an outstanding clinician.

H. M. F. Behneman, M. D.

Peter Arthur Tobin
1887–1938

The San Francisco County Medical Society lost one of its more recent, but highly valued members, in the death of Peter Arthur Tobin on November 20 last. Doctor Tobin was educated in the public schools of Denver, and received the first part of his medical education at the University of Colorado. He received his medical degree at the University of Cincinnati in 1912, and interned at Christ's Hospital. Doctor Tobin had a very extensive general practice in Fresno, California, from 1914 to 1927, leaving there a host of friends. He moved to San Francisco in that year and had been on the visiting staff of Mary's Help and St. Mary's hospitals, as well as in general practice in this city.

Doctor Tobin was an officer in the 143rd Field Artillery, and was overseas for two years during the World War. He was prominent in service clubs, and besides his general practice he carried on a good deal of industrial work. He leaves a widow and several sons to whom the Society has expressed their sincere sympathy.

H. M. F. Behneman, M. D.

THE WOMAN'S AUXILIARY TO THE CALIFORNIA MEDICAL ASSOCIATION[†]

MRS. CLIFFORD A. WRIGHT	President
MRS. FRED H. ZUMWALT	Chairman on Publicity
MRS. FRANK H. RODIN	Assistant Chairman on Publicity

Official Notice

State Board Meeting.—Mrs. Clifford Andrews Wright announces that the next meeting of the officers and board of directors will be held in San Francisco on Friday, February 17 at the Fairmont Hotel.

Component County Auxiliaries

Alameda County

Health Service in Scandinavia was the interesting and timely topic presented by Dr. Walter H. Brown of the department of hygiene and physical education of Stanford University at the meeting of the Woman's Auxiliary to the Alameda County Medical Association held on January 20.

The president, Mrs. Frank Baxter, presided and Mrs. Harry Akesson, Chairman of Public Health, presented the speaker.

About one hundred members and guests were graciously received by the hostesses, Mesdames William H. Sargent and Hobart Rogers, both past presidents of the county and state auxiliaries.

[†] As county auxiliaries of the Woman's Auxiliary to the California Medical Association are formed, the names of their officers should be forwarded to Mrs. Frank H. Rodin, Assistant Chairman of the Publicity and Publications Committee, 2457 Bay Street, San Francisco. Brief reports of county auxiliary meetings will be welcomed by Mrs. Rodin and must be sent to her before publication takes place in this column. For lists of state and county officers, see advertising page 6. The Council of the California Medical Association has instructed the Editor to allocate two pages in every issue to Woman's Auxiliary notes.

Mrs. Hayward Thomas entertained with piano solos.

Reservations were in charge of Mrs. Malcolm Hadden.

Mrs. Grant Ellis, *Publicity Chairman.*

⁂

Fresno County

Preceding the meeting on January 3, twenty members of the Woman's Auxiliary to the Fresno County Medical Association met for an informal dinner at the Magic Cupboard. The president, Mrs. C. M. Vanderburg, presided.

Mrs. R. W. Dalgren reported on the visit to the State Hospital for the Insane at Stockton.

Mrs. Guy Manson reported on the *Hygeia* benefit bridge and Christmas party. With the funds obtained, subscriptions to *Hygeia,* the health magazine, are being placed in beauty parlors, barber shops, schools, public library and clubs. Members are also passing their copies of *Hygeia* on to their friends.

During the Christmas season the members helped to fill stockings for the Indian patients of Bow-Hin-Tow, an annex of Wish-I-Ah Tuberculosis Hospital at Auberry. The chairman, Mrs. Walter J. Avery, carefully selected suitable useful gifts of pajamas, socks, slippers, gay plaid dresses, and bright shirts. These were all wrapped in separate packages with tinsel and ribbons to gladden the hearts of the patients.

The program of the evening was given by Drs. George W. Walker and A. E. Anderson, who spoke on *Socialized Medicine.*

Mrs. Charles H. Ingram, *Publicity Chairman.*

⁂

Orange County

The December meeting of the Auxiliary to the Orange County Medical Association was held at the Laguna Beach Hotel. Thirty-two members and guests met for luncheon.

The business meeting was held in the Ship Salon, overlooking the ocean, and was presided over by the president, Mrs. Hiram Currey.

The philanthropy chairman, Mrs. Harry Huffman, reported on the work of the Auxiliary. The members voted to renew twelve subscriptions to *Hygeia* and the *Readers Digest* in Braile for the blind in the county. Fruit cakes, baked and donated by one of the members, Mrs. D. C. Cowles of Fullerton, netted the Ways and Means Committee $58, to be used for philanthropy.

Two new members from Laguna Beach, Mesdames B. J. Van Doren and W. H. Whimp, were welcomed into the Auxiliary.

The following guests were introduced: Mesdames R. Emerson Bond, Vice-President, San Diego County Auxiliary; F. G. Lindemulder, Councilor for First District; Bergman of Fullerton, and Cooper of Peru.

Mrs. Kenneth H. Sutherland, Program Chairman, presented Mrs. Mona S. Smith of the Santa Anna Library, who reviewed the book *I'd Rather Be Right* by George Kaufman and Moss Hart.

Mrs. G. Wendell Olson, *Publicity Chairman.*

⁂

Riverside County

The doctors of the Riverside County Medical Association entertained as their guests the members of the Woman's Auxiliary at a delightful dinner at the Mission Inn on November 14. The president, Dr. Denver D. Roos, presided.

After dinner a most interesting and fascinating film was shown by Dr. Elmer Belt of Los Angeles, depicting the steps by which Dr. William Harvey demonstrated the circulation of blood. Another interesting film, that of a heart functioning after the patient's death, was shown by Dr. Myron Prinzmetal of Los Angeles.

* * *

The December meeting was held at the home of Mrs. Roy B. McCarty and was well attended. Mrs. W. W. Roblee, President, presided.

Following the business meeting a most interesting talk was given by Dr. Frances Keller Harding on *Medicine Down Under.* She also showed a film of the Fiji Islands. Dr. Frances K. Harding and her husband, Dr. Warren Harding, II, have practiced medicine in Australia for five years.

Mrs. A. W. Walker, who was the first president of the Riverside County Auxiliary and has served on the State Auxiliary Board, was presented with a wrought-metal tray. Mrs. Walker is leaving Riverside to reside on their ranch in Vista, California, and will be missed by the Riverside Auxiliary.

At the conclusion of the meeting the doctors of the Medical Association joined the ladies for a social hour and refreshments. The hostesses were Mesdames Ray McCarty, Bon O. Adams, and S. H. Keller.

Mrs. T. A. Card, *Publicity Chairman.*

⁂

San Diego County

The members of the Woman's Auxiliary to the San Diego County Medical Association met for luncheon on December 13 at the University Club. Eighty members and guests attended.

A short three-act comedy, very capably written by Mrs. Willard Newman, and directed by Mrs. Phraser McPherson, was presented. The dramatic treat, entitled *How Do You Like Your Medicine?* or *Can You Take It?,* was warmly accepted and much enjoyed by all. Dealing with the subject of medicine past, present, and future, it brought many laughs. The cast, author and director, all members of the Auxiliary, agreed it was worth all their efforts.

Mrs. H. K. Albertson, *Publicity Chairman.*

⁂

San Joaquin County

The January meeting of the Woman's Auxiliary to the San Joaquin County Medical Association was held at the home of Mrs. G. H. Rohrbacher. Mrs. G. K. Weaver, President, presided. Sixteen members were present.

An interesting talk on the *Function and Needs of the Juvenile Court in the Field of Child Guidance* was given by Miss Eileen Clark of the Juvenile Court.

The meeting concluded with the serving of delicious refreshments.

Mrs. G. K. Weaver, *President.*

NEVADA STATE MEDICAL ASSOCIATION

W. H. FROLICH, East Ely	President
C. W. WEST, Reno	Vice-President
HORACE J. BROWN, Box 698, Reno	Secretary-Treasurer

Minutes of the Thirty-Fifth Annual Meeting of the Nevada State Medical Association, Held at Reno, Nevada, September 23 and 24, 1938

I. Scientific Program

The thirty-fifth annual meeting of the Nevada State Medical Association was called to order at 9:45 a. m. on Friday, September 23, 1938, at Bowers Mansion, with President Harry W. Sawyer in the chair.

The first order of business was the address of President Sawyer on "Medico-Economic Problems."*

The scientific program was then taken up.†

At the conclusion of the scientific program recess was taken for lunch, which was served in the patio at Bowers Mansion.

II. Business Meeting

The meeting was called to order at 2: 30 p. m. by President H. W. Sawyer.

Report of Various Committees

Dr. J. La Rue Robinson offered the following remarks at this time:

Resolution No. 1

Whereas, The Nevada State Medical Association hereby affirms its willingness to coöperate at all times with the proper authorities in order to secure adequate medical care for all indigent persons, but at the same time is convinced that such care is distinctly a community responsibility and is properly a function of the local governmental unit and local medical profession; therefore, be it

Resolved, That the Nevada State Medical Association, in justice to the medical profession of the state, hereby records its opposition to and its unwillingness to coöperate in any plan that involves federal supervision and control of medical practice in the United States, and will combat this with every means at its command.

Dr. Robinson: Personally, I think the President's talk this morning is the keynote of whether you want to adopt that policy or not. This is very ambiguous. We are still offering our services to the indigent, but with a string on it. Personally, I feel like Doctor Sawyer—that evolution and times have changed whereby the physician should agree with the Government, which is trying to blow this $850,000,000. I have always felt, and Doctor Creveling knows I have argued, if the doctors don't do something the laymen will do it for you. Why not step up and organize some sort of program and get a fair remuneration for everything you do? It is the public's duty to pay for their injuries; they always have, but they have done it in a poorhouse way instead of a professional way. I think this resolution that we passed last year doesn't mean anything at all. Mr. President, to bring the matter to a head, I think the sentiments that you expressed in your speech this morning should be adopted by the Society as their feeling toward the Government entering into the medical field with that $850,000,000, and with emphasis put on the fact that the physicians should be brought to the fore in planning and in distribution of this money and for the building of necessary rather than unnecessary hospitals for hospitalization and give the help where it is really needed and can be used at the discretion of the doctors. . . .

The question has come up, are we going to adopt the Constitution and By-Laws in accordance with the American Medical Association and follow their plan and incorporate as a nonprofit organization? That question has come up in Minnesota. The Government is now suing the American Medical Association for monopoly, and this is our suggestion: If this Association is going to adopt this we shall probably proceed to incorporate under the state laws of Nevada.

Dr. H. W. Sawyer: Under the heading of "New Business," this is a proposed constitution and by-laws. The business before this meeting this afternoon is to read and accept or reject in all or in part this proposed constitution and by-laws.

Dr. A. R. Da Costa: We have been running for years without any constitution and by-laws. Our secretary was unable to find any by-laws of any kind. A few amendments have been passed from year to year, so it was necessary to start from scratch. We got copies of the proposed by-laws for state associations from the American Medical Association. These could not be followed altogether by our Association. They have a House of Delegates, and we have not. In some parts we have had to go as far as we could following the American Medical Association and then put in what we thought was necessary for this society. Doctors Creveling and Sullivan were on this committee with me, and these have been approved by the committee.*

After hearing the report of the Committee on Constitution and By-Laws—A. R. Da Costa, Earle E. Creveling, and John J. Sullivan—Doctor Da Costa made a motion that the by-laws, with the corrections, be adopted. The motion was seconded by Doctor Creveling. Carried, and so ordered.

Dr. Da Costa: I move that this society, the president, first vice-president, and secretary constitute a committee to incorporate this society, with whatever expense there is to be borne by the treasury. The motion was seconded by Doctor Creveling. Carried, and so ordered.

Dr. Sawyer: It is now time to take up unfinished business. I shall turn that over to you, Doctor Robinson.

Dr. Robinson read the following letter from the California Medical Association which was addressed to Dr. Horace J. Brown, Secretary, Nevada State Medical Association:

Your letters concerning coöperation by the California Medical Association with the Nevada State Medical Association were submitted to the Committee on Public Relations at its meeting held on August 27, 1938.

For your information, that committee voted to recommend that the Council of the California Medical Association authorize a plan whereby it would be possible for the Nevada State Medical Association to secure for its members subscriptions to California and Western Medicine. The subscription price to be on an estimated cost basis of $3 per member. The additional stipulations were as follows:

1. That the Nevada State Medical Association shall pay the sum of $3 for every member of its Association in order that a copy of California and Western Medicine may be sent to each Nevada State Medical Association member.

2. That the transactions of the annual session of the Nevada State Medical Association and of its component county societies would be printed under the same regulations as apply to California Medical Association sessions.

3. Concerning papers read at an annual session of the Nevada State Medical Association, the same rules for acceptance and publication will hold as apply to papers read at an annual session of the California Medical Association.

In your letter you stated you would hold a meeting at Reno on September 23 and 24, and I am therefore sending you this informal memorandum in order that your constituted authorities may consider the same.

With all good wishes for a successful annual session,

Cordially and fraternally,

(Signed): George H. Kress, M. D.,
Secretary.

A motion was made by Doctor Robinson that the Association go on record as having all members subscribe, at $3 per member, to receive California and Western Medicine, and to have it the official publication. The motion was seconded. Carried, and so ordered.

Doctor Robinson then read a letter from the Nevada Tuberculosis Association in which they listed their operations and asked for the Association's coöperation and approval. Doctor Robinson made a motion that the Nevada State Medical Society endorse the activities of the Nevada Tuberculosis Association. The motion was seconded by Doctor Paradis. Carried, and so ordered.

Doctor Robinson read a letter from J. O. Thorpe, General Manager of the Intercoast Hospitalization Insurance Association. He then made a motion that the Association endorse this plan. The motion was seconded. Carried and so ordered.

New Members.—The Secretary presented the names of several applicants for membership, which were as follows:

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* Address of President H. W. Sawyer appeared in California and Western Medicine, January, 1939, on page 20.

† For titles of papers with names of authors, see California and Western Medicine, January, 1939, on page 56.

* Draft of the proposed by-laws was then submitted.

Drs. Arthur Floyd Gardner, Theodore Verner Ross, Bard Sherman Berry, Arthur F. Goodyear, John Edward Hughes, Lemuel R. Brigman, and Leo Frank Corvino. The aforesaid applicants were unanimously approved. Doctor Da Costa made a motion that the name of Doctor Lang be included in the names of the applicants and that he be requested to fill in a formal application. The motion was seconded. Carried, and so ordered.

Honorary Members.—Following the usual procedure, all essayists not already members were elected to honorary membership in the Nevada State Medical Association.

Election of Officers.—The election of officers being next in order, the President called for nominations. Dr. W. H. Frolich of East Ely was nominated for president by Dr. Creveling and seconded by Dr. Moulton; Dr. C. W. West of Reno was nominated for president-elect by Dr. Creveling and seconded by Dr. Da Costa; Dr. H. A. Paradis was nominated for the office of first vice-president; Dr. George McGee was nominated for second vice-president; and Dr. Horace J. Brown of Reno was nominated for secretary-treasurer.

Trustees.—Under the new constitution, Dr. R. P. Roantree of Elko was nominated for the three-year term, Dr. Fleet H. Harrison of Reno for the two-year term, and Dr. Earle L. Creveling of Reno for the one-year term.

There being only one person nominated for each position, the above-named doctors were unanimously elected to the office for which they were nominated.

Doctor Robinson advised that Dr. Horace Brown had recommended that Dr. Fleet H. Harrison be made a life member without the payment of dues. This was put in the form of a motion by Doctor Moulton and was seconded by Doctor Robinson. Carried, and so ordered.

A motion was made by Doctor Paradis that the next annual meeting be held in Reno. The motion was seconded by Doctor Piersall. Carried, and so ordered.

There being no further business the meeting adjourned at 4:30 p. m.

* * *

The following members were in attendance at various times during the session:

H. W. Sawyer, W. H. Hood, Fallon; V. M. Cobb, J. H. Stickler, Stewart; T. S. Bambauer, Bishop, California; Bard S. Berry, E. E. Hamer, James Thom, John E. Worden, Carson City; W. H. Frolich, East Ely; W. M. Ririe, Ruth; C. E. Secor, Elko; Anna Dechene, San Francisco, California; George McGee, Yerington; F. M. West, Lovelock; J. E. Hughes, Winnemucca; J. R. Weisser, Hawthorne; Robert R. Craig, Tonopah; G. S. Martin, Susanville, California; Ernest G. Hand, Gardnerville; J.LaRue Robinson, Harry E. Fightlin, George L. Servoss, Earle L. Creveling, A. E. Landers, J. A. Norton, George A. Cann, Fleet H. Harrison, L. R. Brigman, H. Earl Belnap, C. E. Piersall, Lawrence Parsons, J. A. Fuller, O. C. Moulton, A. R. Da Costa, Arthur F. Goodyear, T. H. Harper, C. W. West, J. P. Tuttle, S. K. Morrison, William Cann, Dwight L. Hood, F. W. Scott, Leo F. Corvino, T. C. Harper, John J. Sullivan, Louis E. Lombardi, Reno; C. D. Lambird, H. A. Paradis, Sparks.

* * *

The following honorary members and visitors were also present at various times during the session:

R. A. Cushman, Talmage, California; A. R. Kilgore, Miley B. Wesson, Leo Nannini, Ernst Gehrels, San Francisco, California; W. H. Daniel, Robert E. Henry, R. N. Smiley, Los Angeles, California; Albert H. Rowe, W. W. Wiley, Oakland, California; C. G. Newburker, Hanford, California; R. P. Landis, Grass Valley, California; John A. Cooper, Mayor, W. E. Pettis, E. C. Whiting, Lester J. Hilp, Reno; W. B. McKnight, Portola, California; Joseph E. Tillotson, Colusa, California; J. B. Rackerby, Joe Wicarius, John H. Lamberg, E. Benjamin, A. J. Afflich, H. W. Shiell, J. O. Thorpe, Sacramento; Lee H. Townsend, Piedmont, California.

* * *

Nevada State Medical Association Committees:

Judicial—H. W. Sawyer, Fallon; E. E. Creveling, A. R. Da Costa, H. J. Brown, J. P. Tuttle, V. A. Muller, Reno.

Program—H. J. Brown, Reno; O. Hovenden, McGill; C. E. Secor, Elko.

Military Affairs—R. P. Roantree, Elko; F. R. Mildren, Las Vegas; Dwight Hood, Reno; T. J. Bluechel, Minden.

Necrology—Mary Fulstone, Smith; J. N. Van Meter, Las Vegas; J. J. Sullivan, Reno.

Public Health—E. E. Hamer, Carson City; J. A. Norton, B. H. Caples, Reno.

Entertainment—S. K. Morrison, O. C. Moulton, T. C. Harper, Reno.

Industrial Health—R. A. Bowdle, East Ely; R. R. Craig, Tonopah; O. Hovenden, McGill.

Council—H. K. Wilson, Fallon; J. R. McDaniel, Jr., Boulder City; E. G. Hand, Gardnerville; A. J. Hood, Elko; G. J. Sylvain, Goldfield; D. J. Hurley, Eureka; J. E. Hughes, Winnemucca; J. H. Hastings, Pioche; G. R. Magee, Yerington; D. A. Smith, Mina; H. J. Valenta, Tonopah; James Thom, Carson City; Alex Coblentz, Lovelock; John A. Fuller, Reno; G. O. Bradley, Ely.

HORACE J. BROWN, *Secretary-Treasurer.*

Environmental Causes of Eczema.—The most striking fact about infantile eczema is the part that environment plays in its production and cure, Marion B. Sulzberger, M.D., New York, says in *The Journal of the American Medical Association* for January 7.

Environmental allergens include particularly house dust and the substances coming from pillows, mattresses, bedding, rugs, draperies and dyed and colored furnishings. It is therefore expedient to remove all sources of such dusts.

The room should be as bare as barracks, with washable walls and floors, if possible. An iron cot with a sterilized horsehair mattress and plain, painted wooden chairs should constitute the bedroom furniture. If kapok and feathers cannot be removed, the mattress, pillows or other articles containing these allergens should be covered with so-called allergen-proof covers.

Whenever possible, these precautions should be taken as a routine not only because they sometimes result in striking improvement of the eczema but because some infants with eczema are potential candidates for future respiratory allergy, in which these environmental dusts may be of prime importance.

If after a reasonable trial of local application of salves or ointments any case of infantile eczema does not improve, it is advisable to eliminate, one by one, such potential common dietary causes as cow's milk, wheat, eggs, citrus fruits, spinach, peas, tomatoes, fish and fish products.

All remedies recommended for local therapy of infantile eczema generally consist of tar, mercurials, resorcinol and sulfur—in manifold forms and combinations—and of these crude coal tar or one of its derivatives is the acknowledged best.

Scratching, because of intense itching, should be prevented through tying of hands and feet, through splints, by means of metal cups on the hands or by the use of mild sedatives. Proper splinting and tying of the hands and feet may at first seem cruel, but these measures are often the kindest in the long run, as they prevent scarring and possible secondary infection.

"Eczemas" of various types, forms and causes, rank with the common cold and acne as perhaps the most frequently encountered of all human ills. The skin is not only the most delicate and the most exposed organ; it is also that organ which protects the individual from the outside world, and helps to adapt him to his environment.

All the new substances of the outside world—dust, feathers, wool, silk, animal emanations, gases, vapors, cleansing agents, caustics (soaps!)—begin their onslaught on the skin of the newborn infant, which must also adjust itself to the varying physical forces—heat, cold, light, moisture, friction, pressure.

The hordes of living microörganisms—fungi, bacilli, cocci and viruses which begin to settle on the surface of the skin and take up their activities there—must be controlled and resisted. In addition to all these external attacks, the skin must learn to cope with the products of diet and digestion and of substances absorbed by inhalation.

Any considerable change in weight, either by addition or reduction, should not be attempted without consulting a physician.—*Hygeia.*

MISCELLANY

Under this department are ordinarily grouped: News Items; Letters; Special Articles; Twenty-five Years Ago column; California Board of Medical Examiners; and other columns as occasion may warrant. Items for the News column must be furnished by the fifteenth of the preceding month. For Book Reviews, see index on the front cover, under Miscellany.

NEWS

Coming Meetings

American Medical Association, St. Louis, Missouri, May 15 to 19, 1939. Olin West, M. D., Secretary, 535 North Dearborn Street, Chicago, Illinois.

California Medical Association, Hotel Del Monte, May 1 to 4, 1939. George H. Kress, M. D., Secretary, 450 Sutter Street, San Francisco.

One-hundredth Semi-Annual Meeting of the Southern California Medical Association, Los Angeles, March 15 and 16, 1939. John B. Doyle, M. D., Secretary, 1930 Wilshire Boulevard, Los Angeles.

Medical Broadcasts*

Los Angeles County Medical Association

The radio broadcast program for the Los Angeles County Medical Association for the month of February is as follows:

Thursday, February 2—KECA, 10:45 a. m., The Road of Health.
Saturday, February 4—KFI, 9:00 a. m., The Road of Health; KFAC, 11:30 a. m., Your Doctor and You.
Thursday, February 9—KECA, 10:45 a. m., The Road of Health.
Saturday, February 11—KFI, 8:00 a. m., The Road of Health; KFAC, 11:30 a. m., Your Doctor and You.
Thursday, February 16—KECA, 10:45 a. m., The Road of Health.
Saturday, February 18—KFI, 9:00 a. m., The Road of Health; KFAC, 11:30 a. m., Your Doctor and You.
Thursday, February 23—KECA, 10:45 a. m., The Road of Health.
Saturday, February 25—KFI, 9:00 a. m., The Road of Health; KFAC, 11:30 a. m., Your Doctor and You.

Memorial to Dr. Joseph Pomeroy Widney, Founder of the Los Angeles County Medical Association.—On Wednesday morning, December 7, 1938, memorial services for Dr. Joseph Pomeroy Widney were held on the campus of the University of Southern California.

Services were under the auspices of the Conservation Committee of the Eschscholtzia Chapter of the Daughters of the American Revolution.

A memorial tablet, inscribed

Joseph P. Widney, M. D.
Patriot, Scholar, Pioneer
President, University of Southern
California, 1891–1896

was unveiled by Mrs. Samuel A. Widney.

Dr. Rufus B. von KleinSmid, President of the University of Southern California, accepted the memorial and paid tribute to Doctor Widney.

Members of the Los Angeles County Medical Association attended the ceremony in honor of Doctor Widney, motivating leader of the founders of the Association. Biographical and other sketches concerning the late Doctor Widney have appeared in previous issues of CALIFORNIA AND WESTERN MEDICINE. (See issues of April, May, June, 1936; and August, 1938, on pages 106 and 161.)

Ancient Judean Medicine Similar to Modern Type.—The medical practitioners of ancient Judea had theories and techniques on infections and their results that appear surprisingly modern, it is revealed in a rare volume that has come to the Crummer Room library of the University of California Medical Center here. The volume, written early in the eighteenth century by Dr. John Jacob Schmidt, a German physician, is titled "Medicine and the Bible," and is a collection of all references to disease and remedies that occur in the Old Testament.

Resident Physician Wanted.—There will be an opening for resident physician at the Alameda Sanatorium, Alameda, California, beginning July 1, 1939.

Seventy-five bed, private hospital with a daily average of forty patients, including all services except contagion and mental. Salary of $125 and full maintenance. Duties to include histories and physicals on patients and their routine follow-up care under supervision of the attending physician, and also the giving of occasional anesthetics. Some opportunity for assisting in surgery. License in California obligatory. Anyone who would be interested in the position will please communicate with Ruth A. Wescott, Superintendent, for further information.

Rôle of the Neutron. — The neutron, discovered by Chadwick, and of special interest because it carries no electric charge, can now be obtained in a beam available for direct use as a possible future form of radiotherapy. An apparatus, called the cyclotron, for the production of this beam is described in the *Journal of the Canadian Medical Association* for March, 1938, by Prof. J. Stuart Foster of McGill University. The cyclotron, which is comparatively simple in design, depends in principle on the fact that given certain conditions the ions circulating in a magnetic field can be rapidly accelerated so that they finally strike a target with an energy of five and a half million volts. The fact that it is simple in design does not mean that the cyclotron is easy to construct or operate. The bottom section of the electromagnet weighs eighty-five tons, and the intensity of the primary cyclotron beam is enormously greater than that from any other known source of radio activity. The beam has two possible therapeutic applications—for the direct radiation of patients and for the production of new nuclear forms such as radio-sodium. This has a half-value period of fourteen and eight-tenths hours, and finally loses all radio-activity and passes to a magnesium nucleus of mass 24. The magnesium nucleus is formed in an "excited" state, but becomes normal immediately with gamma-ray emission, ordinary sodium being thus turned into ordinary magnesium as a result of activation by the cyclotron beam. Trial of the neutron beam for the actual treatment of malignant disease may be expected. E. and J. Lawrence at Berkeley are already carrying out biological experiments with tumor implants in mice and other subjects. The use of radio-sodium to make "bombs" is suggested by Prof. Stuart Foster, and since radon has been used in this form for many years in certain American clinics, the idea does not seem to be beyond practical possibilities. The biological effects of neutron beam are already being studied in this country in the hope of extending the scope of radiation therapy.—Extract from *The Lancet,* London, May, 1938.

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* County societies giving medical broadcasts are requested to send information as soon as arranged (stating station, day, date and hour, and subject) to CALIFORNIA AND WESTERN MEDICINE, 450 Sutter Street, San Francisco, for inclusion in this column.

East Bay Hospital Conference.—Alfred E. Maffly, Superintendent of the Berkeley General Hospital, recently was elected president of the East Bay Hospital Conference, succeeding Ellard L. Slack of Samuel Merritt Hospital. The new vice-president is Miss Florence Klaeser of East Oakland Hospital, and the new secretary-treasurer is John Rafter of Richmond Cottage Hospital.

The East Bay Hospital Conference is composed of all the hospitals in the East Bay area which maintain the standards approved by the American College of Surgeons. Its membership includes the following hospitals: Alameda County, Alameda Sanatorium, Alta Bates, Berkeley General, Children's, Cowell Memorial, East Oakland, Fairmount, Samuel Merritt, Peralta, Providence, and Richmond Cottage hospitals.

American Board of Obstetrics and Gynecology.—The general oral, clinical and pathological examinations for all candidates, Part II Examinations (Groups A and B), will be conducted by the entire Board, meeting in St. Louis, Missouri, on May 15 and 16, 1939, immediately prior to the annual meeting of the American Medical Association. Notice of time and place of these examinations will be forwarded to all candidates well in advance of the examination dates.

Candidates for reëxamination in Part II must request such reëxamination by writing the secretary's office before April 1. Candidates who are required to take reëxaminations must do so before the expiration of three years from the date of their first examination.

Application for admission to Group A, May 1939, examinations must be on file in the secretary's office by March 15.

Application blanks and booklets of information may be obtained from Dr. Paul Titus, Secretary, 1015 Highland Building, Pittsburgh, (6) Pennsylvania.

Paris Physicians Protest Against Social Insurance.—The abuse of free medical care by the public hospitals and dispensaries and the illegal extension of the original function of the social insurance authorities are arousing the French medical profession to make a vigorous campaign to put an end to a movement which renders it difficult for physicians to earn a living, the regular Paris correspondent of *The Journal of the American Medical Association* reports in the December 10 issue. In the notice sent out by the association of physicians in the department of the Seine, in which Paris is situated, for a meeting to be held on November 4, 1938, the following plea was made for a full attendance:

It is becoming more and more difficult, in fact almost impossible, to practice in Paris and the adjacent areas.

The public hospitals and dispensaries, which are not subjected to the excessively high taxes which physicians must pay, are doing all they can to give free medical attention without any inquiry as to the ability of the sick to pay. Such institutions should treat only indigents.

The social insurance organization was created to insure the worker earning up to a certain sum annually, now 30,000 francs, so that he might be able to pay for medical care. Instead of limiting their activities to this commendable objective, the social insurance authorities have begun to make serious inroads on the work of private practitioners by attempting to organize facilities for treating the insured worker. Every effort is being made to turn the insured from specialists and general practitioners by urging them to enter public hospitals or receive treatment at the many public dispensaries.

The situation has become so acute that the time has arrived for a more energetic campaign against these abuses, which make it impossible for a physician, after many years of preparation, to compete with the tendency toward state medicine.—*American Medical Association News.*

Army Examination Set for Doctors.—Young doctors who wish to qualify for appointments as first lieutenants in the Medical Corps of the regular army will have an opportunity on March 20 to 24, the War Department announced today.

Examinations will be held to fill vacancies occurring during the next calendar year.

Male graduates of acceptable medical schools who have completed one year's internship in an approved hospital, or who will have completed internship by June 30, are eligible. Doctors must not be over thirty-two years of age.

The examination will consist of physical and written subjects.—San Francisco *Call-Bulletin,* December 31, 1938.

State University Plans Classes for Teachers of Blind. Coöperating with the National Society for the Prevention of Blindness, the University of California will include special courses for the preparation of supervisors and teachers of sight-saving classes in its 1939 Summer Session curricula at Los Angeles, according to an announcement made recently by Dr. J. Harold Williams, Dean of the Session.

To give instruction in the administration, supervision and teaching of sight-saving classes, Miss Frances Blend, Principal of the School for the Blind and Sight-Saving in Los Angeles, will join the Summer Session faculty. In addition, special lectures will be given by specialists on ocular problems and students will be given an opportunity for observation in a demonstration class and clinical work in an eye hospital.

Summer Session work begins on the Los Angeles campus of the State University on June 26, with preliminary class bulletins currently available to the public.

Worry and Its Cure.—Clinical proof of the saying that worry causes more deaths and general misery than war, but does so needlessly in many cases, was offered to the staff of the Mayo Clinic in Rochester, Minnesota, by Dr. William J. Kerr, head of the department of medicine of the University of California Medical Center, in a recent invitational address.

Blasted romances, business deals that go wrong and the feeling of lack of personal security, have been determined as the chief causes of the destructive anxiety state in humans, as a result of studies extending over many years, Doctor Kerr said. Withal, the cure appears to be relatively simple, once the patient is aware of the real cause of his condition and takes measures to check that cause.

Characteristic symptoms are overbreathing, which might also be termed too much sighing, which causes the loss of so much carbonic acid gas from the blood that alkalosis sets in, muscular spasms, cramps, palpitation of the heart, trembling, weakness, sweating, numbness of extremities, occasional dizziness and sensations of bands around the head and the neck. These symptoms may be made worse by taking the alkaline substances so often recommended. Relief can be obtained almost invariably if the patient can be shown that anxiety is bringing on the remainder of the symptoms. While it may not be possible to remove the cause of the anxiety, a correction of the overbreathing can bring relief. Avoidance of the alkaline substances and the substitution of acid substances, such as meats, butter and cream, therefor make it more difficult for the symptoms to arise. Sedatives sometimes have a temporary value, but should be taken only as a last resort.

The well-known "soldier's heart," experienced widely during the World War, was merely functional change brought about by the anxiety state, but appearing in more pronounced fashion than in civil life, Doctor Kerr explained.

Doctor Kerr was associated in the study with Dr. Paul Gliebe, psychiatrist, and Dr. Mayo Soley, of the Medical School faculty, Dr. James Dalton of Santa Barbara, and Dr. Nathan Schock of the department of physiology, Berkeley.

Child Institute Receives Grant for Research.—Grants totaling $190,000 have been awarded by the General Education Board of New York for support of the research program at the Institute of Child Welfare of the University of California, according to word received by Dr. Robert G. Sproul, President of the University.

A lump-sum grant of $180,000 has been made for the support of child-guidance studies at the Institute and an additional grant of $10,000 has been provided for use in the general research activities. The entire program is to be under the direction of Dr. Harold E. Jones, director of the Institute.

The Institute research program is devoted to uncovering the methods of mental and physical growth as well as the development of personality characteristics in children.

Ten Commandments of Careful Driving Announced by California Safety Council.—The California Safety Council, a state-wide citizens' safety educational group, recently announced a campaign for careful driving during the holidays to reduce street casualties.

"Ten Commandments of Careful Driving," issued by the Safety Council, are calculated to eliminate hazardous driving and walking and insure a holiday season of prudent driving, in which all California citizens are invited to participate.

Here are the rules:

1. I shall not drive if I imbibe in holiday or party "cheer."
2. I shall not be rude or boorish to pedestrians attempting to cross the street ahead of me, but give them clearance to cross safely.
3. I shall not weave in and out of traffic.
4. I shall not blind approaching motorists at night with my headlights.
5. I shall not hog the middle of the road.
6. I shall not fail to give proper arm signals when turning or stopping my car.
7. I shall not follow too closely the car or truck ahead.
8. I shall not jump signals.
9. I shall not operate my car at excessive speed.
10. I shall obey all traffic regulations, recognizing that my conformance thereto means better "road manners" and less occasion for hazards to emerge.

California Hospital Historical Brochure: "California Hospital Messenger."—Volume 16 of the "Messenger" is a fifty-year memorial number. On its pages may be found references to the group of physicians who in the last half-century played a prominent part in public health and medical practice activities in the southern section of California. For many years the attending staff of senior physicians of the California Hospital, 1414 South Hope Street, Los Angeles, consisted of doctors of medicine who were practically one and the same as the physicians who composed the faculty of the old College of Medicine of the University of Southern California, located on what was then Buena Vista Street, now North Broadway. On page 5 of "The Messenger" is a reproduction of a photograph of the faculty members, and among the twenty-one physicians are the following former presidents of the California Medical Association (former name, Medical Society of the State of California): Henry S. Orme (1878), Walter Lindley (1889), W. Le Moyne Wills (1895), Henry G. Brainerd (1922), and Granville MacGowan (1924).

Four other physicians who, for many years were intimately identified with the California Hospital, and each of whom was likewise a president of the California Medical Association, are H. Bert. Ellis (1903), W. W. Beckett (1908), George H. Kress (1916), and William T. McArthur (1926).

Financial Grants for Cancer Research.—Financial grants for cancer research in designated hospitals and medical colleges were recently considered by the National Advisory Cancer Council at the National Institute of Health.

Distribution plans for the $200,000 shipment of radium which recently arrived in Washington were included in the reports. The nine and one-half grams owned by the Institute are now being tested at the Bureau of Standards. Within the next several months most of this radium will be loaned out in small quantities to hospitals, cancer clinics, and medical centers, in accordance with regulations approved by the Council at its October meeting.

A Symposium on the Public Health Significance of the Virus and Rickettsial Diseases.—The faculty of the Harvard School of Public Health offers a short course of lectures, clinics, and demonstrations on the virus and rickettsial diseases, with special emphasis on their public health significance, to be held at the School during the week of June 12 to 17, 1939. Lectures on the etiology, epidemiology, and methods of control of these diseases, given by members of the faculties and by former students of the Harvard School of Public Health and of the Harvard Medical School, will occupy five mornings. Special clinics and demonstrations will be given each afternoon. In some instances these demonstrations will be continued through the week, so that all the members of the symposium can attend. On the last morning, a panel discussion will be held on the three main topics presented in the symposium.

The fee for the course will be $25, payable at any time up to June 12. Enrollment, however, should be arranged before June 1, as facilities for many of the clinics and demonstrations are limited. The lectures will be published later in a single volume, which will be sent to each person who has registered for the course.

Further information may be had by writing to the Secretary of the School of Public Health, 55 Shattuck Street, Boston, Massachusetts.

Scientific Methods in Disease Control.—Wider application of the methods of science in disease control, greater emphasis on health education, and extension of group activity, both in the practice of medicine and in medical research, were predicted recently by Dr. R. R. Spencer, Executive Assistant of the National Cancer Institute, United States Public Health Service, in an address in Philadelphia before the third annual convention of the Association of Medical Students.

"We are going to see the methods of science applied to the problems of society and the physician will have an important part in solving these problems," Doctor Spencer declared. "Medicine is a social science. It deals with people and their behavior, as well as the behavior of our heart, stomach, thyroid, liver, or kidneys. If science can deal effectively with the misbehavior of our organs, it should be able to deal effectively also with the misbehavior of the organism as a whole."

In commenting upon his predicted expansion of health education, Doctor Spencer said that "preventive medicine will some day be the heart and soul of medical practice, and the heart and soul of preventive medicine is health education." He pointed out that, even today, every medical society has a speakers' bureau and a public relations committee, and commended health education efforts in behalf of preventive medicine because "preventive medicine is far more satisfactory to the patient, to the physician, and to the community than curative medicine. It is less spectacular, but in the long run it is cheaper."

In advocating a closer connection between health education and general education at all levels, including schools, colleges, universities, and classes of mass adult education, the Public Health Service official declared: "You cannot separate health education from the general business of living. Hence, the duties of the public health physician and the school teachers are merging.

"Extension of medical care does not necessarily mean political domination. It should simply mean good organization, and I do not believe good organization means regimentation and the killing of initiative. It should, on the contrary, release initiative, for good organization is synonymous with teamwork and *esprit de corps,* and a trust in what John Dewey has called 'coöperative intelligence.' An enlightened public is demanding a high type of medical care which can be provided only by group practice and the establishment of health centers.

"The day of individualistic competitive medical methods is rapidly passing. Many diseases formerly taken care of by the individual physician have now become major public health problems. Mental diseases, tuberculosis, syphilis, pneumonia, and cancer are included in this group."

A "New" Disease.—As yet unnamed, a new disease of mankind, caused by a recently recognized virus, may soon be added to the long list already known. The infection is found in nature in the Rocky Mountain wood tick, a species native to Montana.

The identity of this infectious agent with the little-known "Q" fever of Australia is suggested by Dr. R. E. Dyer, Senior Surgeon, United States Public Health Service, in one of the series of studies on the new virus appearing in Public Health Reports (December 30, 1938).

In 1926, a filter-passing agent was recovered from a species of tick near Missoula, Montana, by Noguchi; again, nine years later, a virus, possibly the same as Noguchi's, was again recovered from approximately the same locality. This time, Doctors Gordon E. Davis and Herald R. Cox, Bacteriologists of the Public Health Service, began experiments with the unknown strain which eventually resulted in the present reports.

Their research indicates that the new infection, which they succeeded in transferring to guinea pigs, is characterized particularly by high and continuous fever and an enlarged, smooth spleen. Later work by Dr. R. R. Parker at the Rocky Mountain Laboratory, maintained by the Federal Government, proved that the agent of infection could be passed to guinea pigs by both progeny of infected females and immature and adult ticks which had fed, as larvae, on infected blood.

Doctor Cox (in Paper III of the series), working further with the recovered strain, found numerous minute protean organisms which resembled "rickettsia," or bacterium-like forms.

The fourth paper of the series, by Doctor Dyer, reports the actual case of "X," a member of the staff of the National Institute of Health, who contracted the new disease in May of last year, while observing the research on the virus in the laboratory at Hamilton, Montana. The period of incubation is described as about ten days, with gradual onset. Mild fever sets in the third day, lasting about a week, accompanied by chills and recurrent sweating. Finger joints were recorded as "tender" for about three days. The patient returned to normal in approximately one month.

Virus recovered from "X," injected into guinea pigs, gave them a similar infection, and his serum produced definite protection against further inoculation. Other tests indicated the possibility of the new infection being similar in many respects to the newly described Australian disease.

"The possibility that this infecting agent and the one which causes 'Q' fever are closely related, as the 'one-way' cross-immunity tests indicate," Doctor Dyer suggested, "should not be overlooked. That the two diseases may not be identical is indicated by our failure to infect monkeys, while the Australian workers report them as susceptible to 'Q' fever. Epidemiologically, this latter disease has been found in Australia, particularly among workers in abattoirs and among dairy farmers. Such an epidemiological picture is not at variance with the picture of a 'tick-borne' infection, since it suggests a reservoir in animals and the existence of the infection in their arthropod parasites."

Annual Congress on Industrial Health.—The First Annual Congress on Industrial Health was held on January 9 and 10, at the Palmer House, Chicago, Dr. C. M. Peterson of Chicago acting as secretary.

The program follows:

Monday Morning, 9:45

Stanley J. Seeger, M. D., Presiding

Report of the Council on Industrial Health—Stanley J. Seeger, M. D., Chairman, Milwaukee.

Symposium on Industrial Relationships

The Physician in Industry and Organized Medicine—Irvin Abell, M. D., President, American Medical Association, Louisville, Kentucky.

The Physician in Industry and the Employer—C. D. Selby, M. D., President, American Association of Industrial Physicians and Surgeons, Detroit.

The Physician in Industry and the Employee—Loyal A. Shoudy, M. D., Chief of Medical Service, Bethlehem Steel Company, Bethlehem, Pennsylvania.

Industrial Health and the Private Practitioner—R. L. Sensenich, M. D., Trustee, American Medical Association, South Bend, Indiana.

Monday Afternoon, 2:15

Harvey Bartle, M. D., Presiding

The Program of the American College of Surgeons in Industry—Frederic A. Besley, M. D., Chairman, Committee on Industrial Medicine and Traumatic Surgery, American College of Surgeons, Waukegan, Illinois.

Uniformity in Workmen's Compensation Procedure—Voyta Wrabetz, Chairman, Industrial Commission, State of Wisconsin, Madison.

Bases for Coöperation Between Insurance and the Physician in Industry—Ambrose Kelly, American Mutual Alliance, Chicago.

A Program for Committees on Industrial Health in the State Medical Societies—A. D. Lazenby, M. D., Chairman, Committee on Industrial Health, Medical and Chirurgical Faculty of Maryland, Baltimore.

Tuesday Morning, 9:30

H. H. Kessler, M. D., Presiding

The Health and Safety Program of the United States Bureau of Mines—Daniel Harrington, Chief, Health and Safety Branch, United States Bureau of Mines, Washington, D. C.

The Public Health Interest in Industry—Federal, State, and Local—Warren F. Draper, M. D., Executive Officer, United States Public Health Service, Washington, D. C.

Industrial Health Activities by Labor Departments in the Government—Alice Hamilton, M. D., Consultant on Industrial Hygiene, Division of Labor Standards, United States Department of Labor, Washington, D. C.

Independent Programs of Investigation and Prevention—W. J. McConnell, M. D., Secretary, Industrial Hygiene Section, American Public Health Association, New York.

Tuesday Afternoon, 2:00

Leroy U. Gardner, M. D., Presiding

Industrial Surgery from the General Surgeon's Point of View—Harry Mock, M. D., Chicago.

Symposium on Medical Service to Small Industrial Plants

Statement of the Problem—Victor G. Heiser, M. D., and Donald M. Shafer, M. D., Consultants, Committee on Healthful Working Conditions, National Association of Manufacturers, New York.

The Responsibility of the Private Practitioner in Occupational Disease Control—Carey P. McCord, M. D., Director, Bureau of Industrial Hygiene, City of Detroit Department of Health, Detroit.

Means for Accomplishment—Glenn S. Everts, M. D., Philadelphia.

Methods of Appraisal—L. D. Bristol, M. D., Health Director, American Telephone and Telegraph Company, New York.

Press Clippings.—Some news items from the daily press, on matters related to medical practice, follow:

95.000 on Los Angeles Relief, Cost Growing, Says Charities Chief

There are 75,800 cases or approximately 95,000 persons, on the relief rolls in Los Angeles County, according to the report of Rex Thomson, county superintendent of charities, for the first half of the fiscal year which was filed with the Board of Supervisors recently.

Thomson pointed out that the case load was increasing annually and aged aid cases jumped from 6,000 in 1934 to 50,600 for the period ending January 15, last.

While the cost for the year of 1938-39 increased by $10,000,000, Thomson said that relief costs during the next fiscal year will again be materially increased due to the number of aged persons qualifying for old-age pensions.

Of the total case load of 75,800 aged persons receiving an average old-age pension of $32.25 per month totaled 50,600 and the current monthly disbursement was $1,630,000. Of this total, the county contributed $254,300, the state $656,900 and the federal government $718,800.

Thomson pointed out that the average payment to old-age pensioners of $32.25 per month was lower than that paid by other counties in the state. He asserted that many applicants have legally responsible relatives able to assist them, who have refused to do so. The county has no alternative but to approve the application and later seek to collect from responsible relatives in the courts, he said.

Blind aid cases in the county total 3,000 who receive an average payment of $48 per month or a total monthly disbursement of $145,000. Of this total the county contributes $49,900, the state $49,900 and the federal government $45,200. This county has 49.5 per cent of all the blind persons receiving aid in the state, according to Thomson.

Child aid cases total 4,400, calling for an average payment of $46, and a total monthly disbursement of $203,000, of which the county paid $80,000, the state $86,500 and the federal government $36,500.

* * *

Law Bars Citizen From Being Doctor

Because of a strange quirk in California medical laws, Sidney D. Leo, who has a doctor of medicine degree, recently pleaded that he was being deprived of the right to practice in California—simply because he is an American citizen!

However, he won a point in his legal battle to become a physician in California when Superior Judge Emmet H. Wilson overruled a demurrer to his suit, which asks for a writ of mandate against the State Board of Medical Examiners to compel that body to allow him to take an examination for a license.

Law Changes on Him

His action sets forth that he received his medical education in universities approved by the board in Germany and Switzerland, his doctor's degree having been conferred on him by the University of Basle in Switzerland.

While he was busy pursuing his studies in Europe, the California Medical Practice Act was amended to require that an applicant for practice in this state must first have been licensed in the country where the medical school from which he received his degree is located—if he was educated in a foreign country.

Clear Way for Trial

But Leo declared that he cannot obtain a license in Switzerland because he is an American, since that country would require that he be a citizen of Switzerland to become a physician there. However, a Swiss physician could take the California medical examination, because this state has no citizenship requirements, Leo pointed out.

Hence, he says, he is being penalized because he is an American citizen. Judge Wilson, in overruling the demurrer, cleared the way for trial of the writ of mandate suit.—Los Angeles *Herald and Express.*

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Physicians to Oppose State-Ruled Hospital

Proposed Constitutional Amendment Plan Results in Counter-Proposition

San Francisco, December 29 (UP).—Vigorous opposition to a proposed constitutional amendment providing for state-supported hospital and surgical care developed today from physicians now working out a new plan of "socialized medicine" under the aegis of the California Medical Association.

Doctor Pinkham, Secretary of the State Medical Board, joined with other state officers in announcing organized medicine would fight the measure as "impractical" in case it goes to the ballot.

Plan Accepted

The medical association's own proposal for a plan of health insurance has been approved and is expected to be put into operation some time after the first of the year when articles of incorporation have been obtained.

The association's plan provides unlimited medical and limited hospital service to all subscribers, who may choose their own doctor and hospital. It will be limited to those with incomes of $2,500 a year, or possibly may be raised to include those with incomes somewhat above $3,000 a year.

The proposed constitutional amendment was sponsored by Avery Moore, formerly identified with the Townsend pension movement, and proposed to make available to the people of California "the benefits of medical science along the same lines as educational benefits are now being enjoyed."

Hospitals Opened

State hospitals (now crowded to capacity) would be thrown open to the public free and private hospitals would be reimbursed by the state for services rendered. Doctors would be placed under a single state agency which would classify some as full-time employees and assign cases and set fees for those not in the state employ.

The proposal made no specific provision for the financing of the plan but said the costs should be included in the Governor's budget after a year's trial. It was submitted to the attorney general's office for certification of title, the first step to circulating it as an initiative measure for vote at the next general election if sufficient signatures are obtained.—San Diego *Sun.*

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Wants Science Applied to Human Propagation

Editor of The Bee.—Sir: A visitor to Treasure Island is greeted with the last word in scientific advancement in all that will make the exposition a success. He is impressed with the fact that science is the servant of man and administers to all his material wants.

But how about man himself? Poor old genus homo is left out in the cold. True, the medical profession administers science to the ills of man, but man himself is left to propagate in the same old catch-as-catch-can method as the cave man. Biology is the foundation of all living things on this planet, and the quality of the biology determines the quality of that particular thing. This is as true of the human family as it is of the plant or lower animal kingdom.

The dog lover, the horse fancier and the dairy man are all jealous of the quality, the biology, of the particular animal in which they are interested and insist on pedigreed animals that have been bred scientifically. Those interested in plant development apply scientific principles to the development of their particular plants. The gene is the unit of all life, and whether it be prince or pauper, pigs or potatoes, it always reacts the same in the same environment.

Science applied to the plant and lower animal kingdom has wrought marvels in improvement. Science if as intelligently applied to the human family will bring equally good results.

We are producing a great number of people of low intelligence and high fertility, and a small number of people of high intelligence and low fertility. Unless we reverse this trend we will become a decadent people.—Eugene H. Pitts, M.D., Sacramento, December 27, 1938.—Modesto *Bee and News Herald.*

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Army Medic Tests Set

Candidates for appointments as first lieutenants in the medical corps of the regular U. S. Army may take their examinations March 20-24, it was announced recently.

The examinations, which consist of physical quiz, written test in professional subjects, and a determination of the candidate's adaptability for military service, will be conducted by boards of medical officers throughout the United States.—San Francisco *Call-Bulletin.*

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Medical Co-Ops

"Socialized medicine," as some have been calling it, in the District of Columbia and elsewhere, is not an attractive term, nor an accurate one. The term, used to describe a regular medical service by a salaried staff of physicians to a subscribing group of patients, is becoming popular in this country, as it has long been in other capitalist countries. It is a form of the coöperative movement, already applied to many other forms of group buying and selling under private capitalism.

What this amounts to, in its purely medical aspect, is a sort of sickness insurance, guaranteeing medical care within specified limits for a definite monthly fee, and likewise guaranteeing steady employment and regular income for the physicians concerned. Millions of Americans have already availed themselves of such services, under one name or another, and the practice is growing.

It is not evident that there has been much propaganda behind this movement. It seems to have arisen as a natural thing. Medical co-ops were bound to develop, in a highly experimental age, among people of small or fixed income needing medical care, and doctors preferring salaries to an irregular and perhaps inadequate income. The usual result of such arrangements, where they are well managed, seems to be more work for doctors and hospitals and better care for patients.—Chico *Record*.

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Medical "Purge"

A long legal battle over the rights of medical associations to prescribe rules governing the membership has opened with return of indictments by a federal grand jury in Washington. It is almost certain that the issue will be carried to the United States Supreme Court, if necessary. On the outcome hinges not only the character of medical practice in the United States, but also the type of service prospective patients may receive.

The public should have ample time to familiarize itself with the principles at stake, and it should endeavor to comprehend the motives prompting the indictments and the effect on American medicine if the crusade to impose state socialism in medical practice is successful. If prosecution of the medical profession seeks to break down the freedom and initiative of the practitioner and to regiment him through national political control, the public may be expected to ally itself with the American Medical Association and affiliated societies in a common defense.

If the liberal wing of organized medicine, on the other hand, institutes measures which reduce the cost of medical care to low-income groups, the major medical reform will have been achieved. In that event, the government's case probably will collapse of its own weight. Organized medicine should battle vigorously for the maintenance of the traditional relationship of doctor and patient. No service arrangement should be countenanced which does not permit full freedom in selection of a physician and equal professional rights in declining to accept a service call.

The indictment of the American Medical Association, three local medical societies and twenty-one individual physicians, charged violation of the Sherman antitrust act. The Department of Justice made charges in October that some doctors had been threatened with exclusion from certain hospitals, thus restraining their efforts to earn a living. The courts will determine the rights of medical associations to formulate rules governing the conduct of their members, an essential element in the maintenance of professional standards and ethics. The antitrust charge marks only one phase of the campaign to impose state medicine on the country.

While many physicians are aligned with a more liberal wing which opposes the extreme conservatism of most medical associations, they may feel that the prosecution scarcely comes into court with clean hands in what ostensibly is an effort to destroy standards that have been responsible for the profession's prestige. The progress of medical practice surely will be impaired if medical associations are compelled to accept all who apply and to extend hospital and other privileges to any doctors demanding them. The profession and the public have rights as well as some who assume they have been penalized for unorthodox methods.—Indianapolis, Indiana, *Star*.

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New Olson Insurance Bill Likely

A health insurance plan, broader than that recently adopted by representatives of the state's 7,000 physicians in convention at Los Angeles, will be proposed by the Olson administration in January.

The Olson plan would take care of unemployables and indigents and also workers whose incomes are not greater than $5,500 annually.

Limited to $2,200

The physicians' plan would place medical care of the unemployable and indigent in the hands of the state, and confine workers benefited to those earning not more than $2,200 annually.

Assemblyman Sam Yorty of Los Angeles declared several noted physicians and health educators are studying all types of health insurance, and that the bill to be introduced by the Olson administration "will combine the best features of all."

Long a Live Issue

Health insurance has been a live issue in legislative circles for a number of years. In the 1935 session, a leading question was whether state-wide health insurance was practical. The legislature failed to decide.

In 1937 the issue had swung around to voluntary insurance and how it should be handled. During the interim periods, voluntary insurance made headway and agitation for state health insurance increased.—Woodland *Democrat*.

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Free Hospital Plan in State Proposed

Avery C. Moore, a Berkeley attorney and former organizer for the Townsend movement, announced he would sponsor a constitutional amendment that would enable all hospitals in California to be supported, in whole or in part, by taxes and make medical facilities available to all citizens in a manner similar to the present setup, which provides free education.

Moore said he had drawn up his proposed amendment and had sent it to Attorney General U. S. Webb for title.

A commission of nine members, entirely separate from the State Board of Health, would administer the projected free medical aid program.

Under the amendment, present private hospitals would be compensated by the state for services and the commission would buy or build sufficient other hospitals to take care of all the sick. Physicians, surgeons, dentists, registered nurses and others would also be under the health commission's jurisdiction.—San Francisco *Call-Bulletin*.

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State Aid Medical Bookie War Seen

Officials View Program as Impracticable

Sacramento, December 28 (UP).—State officials tonight said that a proposed constitutional amendment which would provide for state supported medicine and surgery would be impracticable and would be opposed vigorously by the medical profession.

The proposal was submitted to the attorney general's office for certification of a title, the preliminary step to circulating it as an initiative measure to be voted upon at the next general election.

It was sponsored by Avery Moore, Oakland, who formerly was identified with the Townsend pension movement. It proposed to make available to the people of California "the benefits of medical science along the same lines as educational benefits are now being enjoyed."

State hospitals would be thrown open to the public free and private institutions would be reimbursed by the state. All medical practitioners would be placed under a single state agency which would classify some as fulltime salaried employees of the state and assign cases and set fees for those not in state employ.

Harry Lutgens, state director of institutions, when informed of the proposal, pointed out that the seven present state hospitals were crowded to their capacity of 22,000 patients and had no room for more. He said present patients pay an average of $20 monthly for treatment, returning about $4,000,000 to the state general fund. But the cost of maintaining the institutions is $14,000,000 biennially and an additional $6,000,000 was spent for construction in the current biennium.

Dr. C. B. Pinkham, Secretary of the State Medical Board, said that medical groups would oppose the plan vigorously.

He said that the various medical groups presently were controlled by individual governing boards having separate requirements.

The initiative as offered to the attorney general made no provision for immediately financing the plan, specifying that funds should be included in the budget by the Governor after a year's trial had determined the cost of maintaining the proposed program.—Los Angeles *Daily News*.

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Colusa County Opens Hospital to All Doctors

Many Officials Are Sworn to Posts in Superior California Towns

Colusa (Colusa County), January 4.—The Colusa Memorial Hospital, long known as a hospital in which a select few physicians were allowed to practice upon approval of the Colusa County Board of Supervisors, has been thrown open to all licensed doctors and dentists of the county by a new set of rules adopted by the Board of Supervisors.

Surgeon Renamed

Dr. Joseph Tillotson has been returned for another year as the hospital surgeon.

Miss Barbara Stephenson, whose régime as superintendent of nurses at the hospital was criticized by the Hospital Committee of the Colusa County Grand Jury late last month, was returned to that position for another year.

Dr. H. S. Powis, Arbuckle osteopath and hospital owner, was elected county health officer to succeed Dr. Ney M. Salter of Williams.

Dr. Charles A. Poage, former president of the Colusa County Health Unit, was named county physician.

The supervisors made it possible for the hospital surgeon to have downtown offices for the care of his private pay patients. Heretofore the hospital surgeon gave his entire time to the institution.

Indigents Get Priority

The rules also fix the priority of use of the operating room and facilities, giving indigents first use, veterans and dependents second place and pay patients third place.—Sacramento *Bee.*

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Other Editors Say—

Medical Health Insurance—More important than the particular form of low-cost health insurance that the California Medical Association plans to launch is the fact that it is instituting some form. This means that the prejudices of a conservative profession have been overcome in this state at least, and a successful experience with the plan adopted here would certainly mean that medical societies in other states would follow suit.

The plan naturally must be launched somewhat experimentally. Its institution therefore must be marked by caution. It must feel its way, not attempting too much at the outset. This evidently is the policy to be pursued.

While it is the hope of the organized physicians to reach ultimately all groups who may want such protection, the association must confine its insurance at the start to relatively safe risks. This will confine the coverage at the start to groups of gainfully employed persons working for reliable concerns. To proceed at once on a more liberalized basis would be to jeopardize the whole experiment.

The first beneficiaries, however, are those of the group most needful for such protection as the plan will give. It is the middle class salary group that is unable to pay the high costs of sickness and yet that disqualifies for most forms of charity aid.

The California Medical Association in taking this step is making a needed and practical contribution to social security but on a nonpolitical basis.—Palo Alto *Times.*

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Insurance Faces Social Legislation

One of the bugaboos of the great American institution of private-enterprise insurance, which has developed far beyond its extent in any other country, is the ever present threat of state operated social insurance. The American institution of insurance has reached its present position as one of the nation's most effective economic stabilizers, through the greatly abused and somewhat frayed "American System of Private Initiative and Enterprise."

Word from Sacramento is to the effect that a state social insurance scheme will be presented at the Legislature this week. This plan, according to available information, will be state operated and controlled, placing in the hands of appointed politicians the health and security of the individual citizen. To pay for this service will be necessary to again tax all employers in California, with a suggestion that this contribution range from 3 to 6 per cent of the pay roll. In other words, the pay rolls of California industry will be boosted by that specific amount without adding a name to the pay roll.

Available Now

Private insurance companies contend that they have service already available; that thousands of employees throughout the United States have this protection individually or through their employer; that in many other instances employees, when given the opportunity, have voted against the plan, although it is entirely voluntary and permits freedom of action in selection of physicians and hospitals.

Since last October the employees of the State of California have been protected under a group health insurance policy, which gives them complete medical, hospital, ambulance, x-ray and other services at a per capita cost of $1.75 per month. They may choose their own doctor and hospital. The service includes the cost of minor or major operations, including hospital and doctor.

Results Gratifying

While admittedly an experiment at this premium rate and by covering the individuals without physical examination, the company involved reports gratifying results and expects that in the first year all of the early problems will be straightened out and that during the second year it will be able, without additional rate, give complete preventive medical service to each state employee.

Reports are also that other large employers have adopted similar programs, the employee and employer both contributing to the cost on a monthly basis. In many of these contracts dependents of the employees are also covered for a more restricted coverage without additional cost . . . which is included in the state employees' contract.

Insurance companies, looking back over 100 years, contend that this voluntary system is better for the morale of the individual and the general welfare of democracy.—San Francisco *Chronicle.*

Mr. Lutgens' Proposals

Harry Lutgens leaves California many good things to show for his four years as State Director of Institutions, the last being some fine suggestions as to how the care of our mentally ill can be improved still further.

Mr. Lutgents, a newspaper publisher, took the position after politicians had done much mischief in the state hospitals and correctional institutions. There was not a report of political meddling during his directorship. He gave the state institutions a sympathetic, businesslike management.

He returns to private life after completing a 13-million-dollar building program. He found in July, 1936, that the institutions were 40 per cent overpopulated; wards were so crowded that patients had to sleep on pads in hallways. The buildings he has started or finished reduce the overcrowding to 17 per cent. At the same time the amount of curative equipment has been increased.

Patients are getting better treatment, thanks to Mr. Lutgens' administration.

Because he has seen to it that the number of doctors and attendants was increased, personnel standards were raised and better working conditions were provided employees all along the line.

Among the unrealized hopes that Mr. Lutgens hands on to his successor and the Legislature are two well-considered proposals.

He says the laws ought to be changed so the insane will be treated as sick people, instead of like criminals. Insanity warrants are served by sheriffs in most counties, and mentally upset persons are held in jail cells, awaiting sanity trial. Mr. Lutgens proposes that the state hospitals send out doctors to examine patients in their own homes and that, with proper hearings and safeguards, patients be taken directly to hospitals rather than to jail.

The second proposal offers far-reaching benefits.

He urges the establishment of mental health centers at both San Francisco and Los Angeles. These centers could do a great work in prevention. Parents could go to them for advice about neurotic children. The general public would be given help on mental hygiene. Research could be carried out. But more important, the two hospitals could serve as points of admission to the hospitals for the insane.

All patients would go first to one of these two centers. Many persons suffering acute upsets might be treated and sent home within a few weeks. Those with chronic ills or disorders requiring longer to overcome would be taken, not from a jail cell or an inadequate detention hospital, but from a good psychiatric hospital to the various state hospitals.

Mr. Lutgens' suggestions and his efficient service are good foundations for the new administration of the institutions.—San Francisco *News.*

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"Doc" Indicted

"Organized Medicine Indicted as Trust," says headline. Which gets into a big subject, very big indeed—one that touches not only every doctor but every other son of man who has been afflicted with any ill which flesh is heir, from bellyache to coronary thrombosis.

For some reason or other the headline reminds us of a story, attributable, if our memory serves us right, to the late Lincoln Steffens.

The devil, as the story goes, grew alarmed at a report that sin wasn't doing so well in a certain remote community of his realm. He sent a lieutenant to investigate. The report returned, after careful inspection, was that not a grain of evil could be found.

"Is that community organized?" asked the devil.

"No," replied the emissary.

"Well, that's what's wrong," said the devil. "Organize it!"

This is an age of organization. And organization up to a point is essential in as intricate a civilization as ours. But organization can become too refined—whether it be organized business, organized art, organized labor, or organized professions.

So the real test in this suit against the American Medical Association and its allied units is: Has organization gone to seed—has the economic aspect been exalted under the guise of professional ethics to a point where, as the indictment alleges, the "peace and dignity of the United States of America" are threatened?

* * *

Without seeking to try the case or to restate all the issues set forth by the District of Columbia Grand Jury, we do want to say this about "Doc":

Whether he be on one side or the other in this controversy between the American Medical Association and the group health associations, we think that medicine, of all occupations, is least motivated by the acquisitive impulse. We've all needed Doc. We all have been willing to give our shirt and the fillings from our teeth if he would only come right now, and then we all have kicked about his bill if it was more than $2.00, after we got well.

The very nature of his work—the strange ambition which makes one human being want to spend seven or eight years learning the anatomy of other human beings in order to keep their microbes on straight—has always been a mystery to us. From the old country doctor to the most modern and steam-saturated specialist, it's a service that can't, by its very nature, be essentially mercenary. Commercially, you could go farther and acquire more, applying the same amount of energy and intelligence, in the shoe business, where the telephone doesn't ring in the middle of the night.

But maybe this inherently noble vocation has, as the Steffens story puts it, become overorganized.

Anyhow, that's the question in this antitrust case.—San Francisco *News*.

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Medicine

One of the most cheering sights we have ever witnessed was the recent spectacle in Sacramento of doctors and farmers rubbing shoulders together in seeking an adequate solution of the problem of adequate medical care for rural communities. That's real progress, it seems to us. Give credit for this accomplishment to the forward-looking and progressive Farm Bureau leaders, and to the equally forward-looking and progressive medical men of the state and nation. A fight may accomplish a lot but a real conference will accomplish more. It looks now as if the dreams of Farm Bureau leaders, men and women, for solving the health problems of rural communities and their residents, are coming true at last.—Stockton *Farm Monthly*.

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Patterson Sees Action on State Insurance Plan

Sacramento, December 20 (UP).—Lieutenant Governor-elect Ellis E. Patterson, commenting on action taken in Los Angeles by the California Medical Association to inaugurate a health insurance plan, today predicted that similar legislation will be introduced at the coming session of the Legislature.

Patterson, while declining to forecast what action Governor-elect Culbert Olson will take on the proposition, said he hoped that the care of unemployables and indigents will be taken into consideration.

He said it was also to be desired that any such plan of insurance, public or private, permit eligibles to have a maximum salary of $4,000 a year, rather than $2,500, which has been suggested. Patterson said the lower figure, for example, would even prevent the lieutenant governor from obtaining health insurance at reasonable rates since he is paid $4,000 yearly.—Berkeley *Gazette*.

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Advance in Medical Care

Much has been heard of the need for socialized medicine in recent months and years. To meet the requirements of Californians in the low-income group the California Medical Association, by an overwhelming vote, has adopted a plan of health insurance embracing professional and hospital care at low costs. It will be on a voluntary basis.

The plan approved by the convention delegates at Los Angeles is a radical advance, but it was inevitable that it should come. Medical men throughout the country have been seeking ways to make doctor and hospital services available to persons of limited means. The California plan represents six years of study by a special committee. While the program as finally adopted is of pioneering nature, others are coming elsewhere in the country. Utah medicos have just approved a similar plan of coöperative health insurance. New York, Wisconsin and other states are working toward the same end.

The California plan, for the benefit of persons with incomes not exceeding $2,500 a year, calls for monthly premiums expected to be set at approximately $2.50. The larger the response to this voluntary program the more favorable will be the prospect for low premiums.

The plan is expected to be in operation within a few months. The next task—to "sell" the program to the public—should meet a favorable response without requiring hivh-powered salesmanship. A subscriber has the right to choose his own physician and hospital. The program assures, at small monthly cost, freedom from worries over meeting the high cost of medical care which may set back a family for months or years. The plan favors medical attention in time to prevent serious physical developments.

Although the plan has been highly controversial, meeting opposition within the medical profession, it does offer advantages to the doctors. They know they will get some remuneration for their services rather than having uncollectible fees in their books. Programs such as that adopted in California—and to be followed in other states—were inevitable to meet changing conditions and to preclude governmental entry in the socialized medicine field.—Stockton *Record*.

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Medical Care Plan

California, which has traditionally led the nation in many progressive measures, such as the initiative, referendum, recall—to mention only a few—again leads with what may be the beginning of a new health era.

Seven thousand California medical men, through their representatives in convention, overwhelmingly adopted a program of state-wide health insurance.

In an editorial at the time the subject of "state medicine" was being discussed here before the American Medical Association, this newspaper pointed out that the wise measure would be a voluntary step in the direction of care for those in the lower income brackets, rather than wait for national or state legislation.

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And that's why this step of the California medical men is so important; because it was voluntary and a real effort by the doctors themselves to solve the problem.

This problem, simply stated, is merely to insure at low cost for those who have incomes under $2,500 a year (or some comparable figure) an ability to have medical and hospital aid.

Much illness, and much final desperate surgery, can be avoided and the ailment successfully treated easily and rapidly and inexpensively if treated in formative stages.

But in the lower-income brackets, persons themselves ill or having ill dependents, often "let it go" in the hope of saving expense—whereas, in fact, the expense may eventually be much greater, often greater than can be borne, in cases where the ailment is not immediately attended to.

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By the physicians' new plan, for a very small sum, indeed, such persons would have a guarantee of the best treatment possible by the doctor of their own choice, as well as hospitalization.

The plan has been worked out carefully but there are yet details to be polished.

That the plan may work is everyone's ardent wish, both from the point of view of the patient and the physician, as well.—San Francisco *Call-Bulletin*.

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State-Wide Medical Insurance on Way

San Francisco, January 14 (AP).—A preliminary organization to set up a state-wide medical and hospital insurance system was formed here today by the California Medical Association.

The Association's council decided to call the undertaking "The California Physicians' Service." It voted to lend the organization $15,000 for preliminary and organizational work.

It designated seven physicians as trustees. The trustees will be in actual charge of the service. They are Dr. Ray Lyman Wilbur, president of Stanford University; Dr. Lowell S. Goin and Dr. Samuel Ayres of Los Angeles; Dr. C. Kelly Canelo of San Jose; Dr. W. Earl Mitchell of Oakland and Dr. Alson R. Kilgore and Dr. T. H. Kelly of San Francisco.

The Association also enlarged the administrative membership of the service to include Doctors Wilbur, Canelo, Mitchell, Kilgore and Ayres, and Dr. Dewey R. Powell of Stockton, Dr. John C. Ruddock of Los Angeles, Dr. Fred B. Clarke of Long Beach, Dr. S. J. McClendon of San Diego, and Dr. John W. Green of Vallejo.

The administrative membership also was expanded to include an undisclosed number of nonmedical members. This membership will act as an advisory and policy-making body for the service.—Los Angeles *Examiner*.

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Health Insurance

Editor, *The Californian*, Bakersfield:

As an average citizen, I am pleased that the local medical society is backing its state organization's plan for health insurance. My income is limited and a long illness would certainly soon exhaust my meager savings. If I can purchase medical and hospital care on a periodic payment basis, I shall be among the first to sign up for it. I am a taxpayer, but I have no desire to use county facilities. In the first place, I want to be able to choose my own physician and nursing care. In the second place, I like to be responsible for myself and not use tax money for my health care. I pay taxes, but I do not want to think that my personal health bill should be added to a public tax bill while I earn an average income. There must be others like myself who will be glad to pay an annual fee for health care.

The plan presented by the Kern Medical Society is a just one, for it entitles me to the best service of the best physicians and surgeons and the best of private institutions. I am willing to pay for that within my means. I am glad that the doctors have taken the lead in providing such a plan and that they recognize the problems of the small income groups. CITIZEN.

Bakersfield, January 10, 1939.

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Doctor Bruck on Board

Two Municipal Health Advisory Appointments Announced

Two appointments to the Municipal Health Advisory Board were announced at City Hall today.

Dr. Edwin L. Bruck, president of the County Medical Society, was named to succeed Dr. William C. Voorsanger, past president, and Lawrence Arnstein was reappointed. The appointments are for four years.—San Francisco *News*, January 6, 1939.

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University Aides to Supervise Los Angeles County Hospital

Answering grand jury suggestions for proposed changes in General Hospital supervision with quick action, the county board of supervisors today called a meeting to approve a plan by which supervision over work in the fourteen medical and surgical divisions of the hospital will be vested largely in medical representatives of University of Southern California and the Seventh Day Adventist Medical School at Loma Linda.

Four hundred and seventy-five attending physicians now on the General Hospital staff will remain so, continuing to do volunteer work as now, it was explained. But at all times there will be on duty in each of the fourteen hospital divisions a supervisor provided by the medical schools. Phoebus Berman will remain medical superintendent of the hospital.

The grand jury, in its report on hospital practices, based many of its proposals on a survey of methods in the San Francisco and Oakland general hospitals. It was announced that the supervisory system to be inaugurated here will follow the method in vogue in San Francisco and Oakland.

In the meeting were to be heard W. W. Nuzum, chairman of the Grand Jury charities and health committee; Eugene Berger, Grand Jury auditor; Dr. Paul McKibben, dean of the medical school at University of Southern California, and Dr. Percy Magan, head of the Seventh Day Adventist institution at Loma Linda.

The Grand Jury was driving to finish its work so that it can be dismissed and the way cleared for selection of a new jury by the end of this week. Although the 1938 jury was ending its duties, there promised to be but little delay in the probe of alleged corruption in Los Angeles city, a major task of the retiring jury during the past month.—Los Angeles *Evening Herald and Express*, January 9, 1939.

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Committee to Improve Los Angeles County Hospital Named

To put in effect recommendations of the County Grand Jury for the reorganization of the Los Angeles County General Hospital, the Board of Supervisors today set up a committee of ten members.

The reorganization program calls for the appointment of twelve supervisors and two directors to be named and paid by the University of Southern California School of Medicine and the College of Medical Evangelists.

These two medical schools will administer and supervise the work of 479 attending physicians.

The change was recommended by the Grand Jury to improve service at the hospital and to reduce the number of days which patients spend there.

It is expected that the new set-up will render greater efficiency and thus make it possible for patients to leave the institution earlier than the present average fourteen-day stay for each patient.

The new committee, named on motion of Supervisor Gordon L. McDonough, includes Dr. Paul McKibben, dean of the School of Medicine, University of Southern California; Dr. Percy Magan, dean of the College of Medical Evangelists; Rex Thomson, superintendent of county charities; Everett Gray, General Hospital superintendent; John H. O'Connor, county counsel; Art Will, Olive View Sanatorium; William Harriman, superintendent of Rancho Los Amigos; Eugene Berger, Grand Jury auditor; Dr. F. M. Pottenger, sanitarium proprietor, and Supervisors Roger Jessup, Oscar Hague and Gordon L. McDonough.—Los Angeles *Evening Herald and Express*, January 17, 1939.

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Fixed Medical Charge Sought

San Francisco, December 29.—A move to bring all physicians, surgeons, dentists, undertakers and hospitals and all their allied services under the control of a state commission which would fix fees and supervise the public administration of medical science was launched yesterday by Avery C. Moore of Berkeley.

Moore, who formerly was associated with the Townsend pension plan, asked the attorney-general's office to give title to a petition which would put the plan on the ballot as a proposed constitutional amendment at the next general election.

The measure would make all doctors, dentists, nurses and other members of the health professions subject to employment in state service.

There would be two classes of such professionals—regular and associate. Regular professionals would receive $2,000 to $7,500 a year salary and devote themselves exclusively to the various types of public health work.

All professionals would be required to become associates in order to qualify even as private practitioners, and would receive fees as fixed by the commission for the performance of professional duties assigned to them by the state. Associates would be permitted private practice also.

The commission, which would be composed of nine commissioners on annual salaries of $5,000 each, would have authority to provide hospitalization and treatment for the entire population of the state "whenever the need becomes evident."

Regular professionals would enter the state service on a voluntary basis but all would owe primary professional responsibility to the state.

Associates would be required to take an oath they would respond promptly to all calls for service on the commission's order.

Hospitals, other than federal and fraternal, would be subject to prosecution on a misdemeanor charge and would expose themselves to the possibility of being closed if they refused to admit and treat any patient in an emergency or if they rejected a commission order for treatment of a patient.—Porterville *Recorder*, December 29, 1938.

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Medicos Against Moore Proposal

San Francisco, December 29 (UP).—Vigorous opposition to a proposed constitutional amendment providing for state-supported hospital and surgical care developed today from physicians now working out a new plan of "socialized medicine" under the aegus of the California Medical Association.

Dr. C. B. Pinkham, secretary of the State Medical Board, joined with other state officers in announcing organized medicine would fight the measure as "impractical" in case it goes the ballot.

The Medical Association's own proposal for a plan of health insurance has been approved and is expected to be put into operation some time after the first of the year when articles of incorporation have been obtained.

The Association's plan provides unlimited medical and limited hospital service to all subscribers, who may choose their own doctor and hospital. It will be limited to those with incomes of $2,500 a year, or possibly may be raised to include those with incomes somewhat above $3,000 a year.—Porterville *Recorder*, December 29, 1938.

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Public Medical Plan Gets Title

Ballot Proposal Backed by Former Pension Promoter

San Francisco, January 28 (AP) — The ballot title of "Public Medical Service" was authorized by the Attorney-General's office today as sponsors of a proposed state health bill prepared to offer a petition to 8 per cent of voters casting ballots for Governor in the last general election

The 8 per cent is essential to procure the proposed bill a place on the next ballot.

The title was sought by Avery C. Moore of Berkeley, former leader in the Townsend pension movement.

Aims of Bill

The bill would provide for the establishment of a nine-man public health commission, and for the founding and maintaining of hospitals.

It also would subject to public service employment by the commission all physicians, surgeons, pharmacists, dentists, optometrists, osteopaths, chiropractors, embalmers, funeral directors, and trained nurses.

All hospitals except federal and fraternal also would be subject to the commission in so far as making facilities available is concerned.

Two Divisions

There would be two classifications:

1. Voluntary enrollment for state service by which enrollees would devote full time and receive an annual compensation.

2. Requested participation for specific work for which a specific fee would be paid.—Los Angeles *Times*, January 30.

The Doctors' Future*

Boys and girls interested in studying medicine these days meet discouraging rebuffs.

"There's no future in the profession," they are told, while the bugaboo of socialized medicine is raised when talk veers around to the topic. The doctors themselves are about as encouraging to youth as a rainstorm to a picnic.

Yet a certain number of students continue to be interested, praise be, and it seems a pity that the money question must always stick up its ugly head when they are choosing a profession.

We are afflicted with disreputable doctors, as everybody knows, and the country seems to be safe for quackery. Yet in spite of this, everybody knows, too, that we couldn't get along without the good ones and that we respect and love them, although we aren't always prompt with our payments.

I am convinced through friendship with a few that the good ones are successful men, whether they make much money or not. Their lives are enriched with gratitude. Mercy is their guardian angel and they know the true happiness that abides with people who love their work better than the cash it brings them.

There will always be a need for excellent surgeons and diagnosticians and even for the plain, kindly, less brilliant men who, besides healing the sick bodies of their patients, give their hearts and souls ease and comfort.

The young people must often believe that adults are too pessimistic. They are justified in such a belief because our croakings are continuous.

"You can't make a living at this; you'll go bankrupt at that; the other field is overcrowded"—so the wailing goes, its implications being, of course, that there's no quick money to be made any more.

No wonder the youngsters so seldom listen to or believe in us. They sense, if they do not know, that there is now and ever will be a crying need for lawyers who are more interested in justice than in fees; for doctors who want to cure the sick instead of making a reputation for doing so, for engineers who will not sell out to grafters, and for politicians who put the state's welfare above their personal ambition.—San Francisco *News*, January 6, 1939.

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Health Program Here Aids Two Thousand Farm Migrants

Care Is Given Workers Who Are Ineligible for State, County Funds

More than two thousand migrant agricultural workers in Fresno County have received medical care and surgical treatment since May 2 under a program launched by the Farm Security Administration to care for the health of the agricultural population who otherwise would have been ineligible to receive aid in time of sickness.

H. E. Stevenson, executive officer of the Agricultural Workers Health and Medical Association, said this number is included in a total of approximately 15,000 patients treated at the eighteen offices of the Association in California and Arizona. He said the total amount expended since the inception of the service in May has been $400,000 for the two states.

1,400 Get Surgical Care

"Medical aid has been provided in nearly 1,400 cases which required surgical care," Stevenson pointed out, "and includes over 400 appendectomies and tonsillectomies which have received all the attention required, including surgery, hospitalization, diet and doctors' fees.

"The Association has cared for over 500 maternity cases, and has been responsible for discovering possible epidemics of scarlet fever and malaria and stopping them before they could start. One camp at Indio was threatened with a scarlet fever epidemic, but serum and doctors to administer it were rushed there and the cases were confined to three children.

Prompt Treatment Given

"Malaria at Tulare also threatened for a time, but prompt medical care stopped that."

Stevenson said there have been but four deaths of migrants who have come in for medical attention. He said prompt action on the part of the more than 1,000 doctors who handle the cases in the two states has been responsible for the low death rate.

He said 90 per cent of all money spent by the Association has gone for medical aid, the rest for administration expenses. Some of the aid provided also includes glasses, where needed; specialists for undernourished children, besides the other treatment given. He said a dental program will be instituted within the next few weeks to care for that phase of the migrants' health.

Set Up in May

The Association was set up in May by the Farm Security Administration to care for California's and Arizona's growing migrant population who have left their homes in the drought states of the Middle West and who did not become eligible for aid under state and county health programs until they had satisfied residence requirements.

The California offices of the Association are located at Fresno, the main office; Merced, Stockton, Visalia, Marysville, Indio, Brawley, San Jose, Bakersfield, Arvin and Shafter. The Arizona offices are at Phoenix, Buckeye, Tollison, Chandler, Yuma and Coolidge.—Fresno *Bee and Republican,* December 31, 1938.

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Treatment of the Insane

This newspaper has several times pointed out the need of changes in the system of handling commitments to state mental institutions. Official recognition of this need was given yesterday by Harry Lutgens, state director of institutions, at a meeting of Governor Merriam's cabinet, when he expressed views similar to those voiced by *The News.*

Under the present system, these sick persons are treated as criminals, being placed in the custody of the sheriff until a sanity hearing can be held. Most counties—like our own —have no special facilities for handling psychopathic cases, and the results are usually deplorable, from the standpoint of the patient and all others concerned.

It is time, true, a period must in some cases elapse between the time a patient is brought in and the time his hearing is held before a superior judge and his commitment papers signed. A patient, no matter how obviously insane, cannot be taken directly to the hospital, but must have his "day in court" when he is examined by competent physicians under the eye of a judge. However, during this interim the patient, who is frequently not at all violent, should not be kept in jail. Establishment of a local psychopathic ward, possibly at the County Hospital, would not only afford a place in which to keep persons awaiting a hearing, but could be used for the treatment of cases not demanding a stay at Agnew.

In medieval times it was sometimes believed that insane persons were possessed by evil spirits and were therefore deserving of some sort of punishment. Now we know that the insane are ill and in need of treatment, the same as any other sick person. They should receive not only a kindly and competent examination in court by physicians and a judge who know what they are doing, but are entitled to "decent" treatment in advance of that hearing.—Editorial, San Jose *News*, December 29, 1938.

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California Medical Case Is Carried to Supreme Court *

Pacific Health Corporation Seeks to Set Aside Lower Body's Ruling

A group medical practice case from California has preceded the antitrust case against organized medicine in appealing to the Supreme Court of the United States.

From San Francisco, a petition for a writ of certiorari has been filed to bring before the Supreme Court an appeal by the Pacific Health Corporation from a California Supreme Court decision that it had practiced medicine without a license.

The California case is quite different in its essentials from the fight here centering around Group Health Association, although both organizations provide medical care to groups of persons paying on the installment plan in advance.

The Supreme Court will take under advisement the petition for a writ, and decide later whether to review the California case.

Furnishes Treatment

The Western unit contracts to furnish medical treatment, when needed, in return for a regular paid-in-advance fee. It employs outside licensed physicians to give the treatment, but the California courts held that the corporation itself was practicing medicine without a license and in violation of the law.

In Washington, Group Health Association employs its own physicians, who are licensed to practice medicine, and operates a clinic, but, unlike the Pacific group, Group Health Association has already been held legal by a federal district court, here, and not a violation of law, either the district medical practice act nor the insurance act. Further litigation on these points, however, is pending here.

Group Health Association Center of Case

Group Health Association is the center of the antitrust case against organized medicine, in which indictments have just been return by a federal grand jury here charging four units of organized medicine and twenty-one leading doctors with conspiracy in restraint of trade for violation of the Sherman Antitrust Act. This case is expected to reach the Supreme Court of the United States.

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* By Mrs. Walter Ferguson.

* For full opinion of Supreme Court of California, see CALIFORNIA AND WESTERN MEDICINE, October, 1938, on page 306.

In California the State Supreme Court had held that employment of physicians by the Pacific Health Corporation to treat members of the Public Health Corporation was a violation of the state medical laws.

In asking the high tribunal to void the decision by the state court, the corporation did not question the validity of the state law in so far as it prohibited any unqualified or unlicensed physician from practicing medicine, but said:

"In so far as the statute, as construed by the highest court of the state, prohibits the petitioner from undertaking to pay for services of licensed physicians, . . . it plainly forbids the exercise of an ordinary property right and denies what the Constitution guarantees under the due process clause of the 14th Amendment.

"The mere circumstance that doctors are selected and paid for by the organizations has no more reasonable relation to the public health than the mere ownership of a drug store by one not a pharmacist."

Court Divided 4 to 3

The California Supreme Court split, 4 to 3, on its decision.

The Pacific Health Corporation referred in its petition to statements by the Justice Department regarding the American Medical Association and added:

"This case is of substantial import, for it is the test case chosen by the organized medical practitioners of the country to terminate, prevent and strike down what they generally term group medicine.

"The real and manifest purpose of the proceeding instituted in the state court was to secure and establish a declaration of law which would rule out all medical service organizations, including the petitioner, whose primary business it is to furnish medical care to the working and poorer classes.

"Neither the petitioner nor any of these other medical service corporations can, under the prohibition of the California statute, continue to render the necessary and beneficial service which they have been rendering to the poor and small-salaried class unless and until the statute is nullified by this court."—Washington, D. C., *Star*, December 22, 1938.

* * *

Health Insurance Progressive Move

Beset by the fear of socialized medicine under governmental administration, the California Medical Association has adoptede a plan of health insurance to be offered to the people of the state. It is yet too early to say whether the plan adopted is the ideal plan or whether it will be adapted to the needs of the people at large.

However, this much may be said: It is a step in the right direction. It is a tardy recognition by the medical profession, even if under pressure, of the crying need of the American public today, the need of greater security against the costs of sickness. The matter of health and accident have long been the most uncertain factors in modern life. Many a family which has been doing nicely while health was with it has been thrown upon the financial rocks through the misfortune of illness or injury. Many parents have suffered agonies of mental anguish through financial inability to provide for the needs of a suffering loved one. Many homes and lives have been wrecked through a failure to be able to meet the trials and costs of long illnesses.

The movement for medical insurance is in the right direction. It may have to be remodeled, expanded or changed, but at least it is a step towards the provision of more adequate medical services to all the people. Having started this move, the doctors should bend every effort to see that it is a success and that if in the suggested form it does meet the needs of the people changes should be made to fit those needs. Only in this way can the medical profession fulfill its obligation to the public and only in this way can it reëstablish the esteem in which it should be held in the public eye.—Editorial, Yuba City *Independent Farmer*, December 23, 1938.

* * *

Editorially Speaking

"The medical profession in California today pioneered a new field of medicine when the State Medical Association adopted a low-cost health insurance program." . . . News item.

* * *

Health insurance for the general public is a proposition that has been attracting increasing attention during recent years as the nation has developed a more acute consciousness of social problems in their general aspects.

For many years, of course, various types of health insurance and group medical facilities have been in force in many parts of the country. But most of these have been operated under private management, exclusive of the medical profession. Medical men, it seems, have hesitated to enter the field on a general scale because of certain aspects associated with the profession's code of ethics and with practices that have prevailed for centuries. The hesitancy has been prompted, to a large extent, by the fear of "socialized medicine."

But the past year has witnessed a marked change in the situation. Instead of remaining aloof, the medical profession has taken a keen interest in the matter and has centered its attention on the problem, working with other agencies toward some sort of solution that will provide better medical care for those of moderate means.

Symbolic of the new attitude is the program recently adopted by the California State Medical Association, which is to be placed in operation within the next three months. Under the plan, subscribers will be provided with unlimited medical and limited hospital service, choosing their own doctor and hospital. Chiefly it is designated to serve wage earners with annual incomes of not to exceed $2,500, which embraces the great mass of citizens.

How the plan will work is something upon which nobody can hazard a guess, since there is no precedent upon which to base a prediction. But doubtless it will appeal to a vast number of people. In any event, the state's medical profession certainly has evidenced its sincerity of purpose in the performance of its basic job—to keep the public well.—Editorial, Eureka *Standard*, December 22, 1938.

* * *

Los Angeles Mayor's Health Plan Approved

Council Favors City's Contracting for Certain Services

The City Council yesterday indicated its agreement with the plan of Mayor Bowron to clear away legal obstacles so that the city may contract with the county, or the state, to furnish certain health services.

Repeal Favored

Specifically, Mayor Bowron asked sponsorship of legislation at Sacramento repealing a provision of the Political Code which prohibits Los Angeles city alone among municipal corporations from making such a contract. His message was referred to the Legislative Committee, whose chairman, John W. Baumgartner, indicated the plan will be carried out.

In his message Mayor Bowron went beyond a contract with the county, suggesting that the state might well look after tuberculous patients, milk and meat inspection and rodent control. He made it clear, however, that he is not committed to any such plan, but recommended that definite action await a thorough study.

Shift Sought

He said that "many powerful, selfish and sinister influences are at work," now that a change in the Health Commission has been effected, to shift inspection and regulation to other hands. He declared his full belief that the new commission will be capable of making a thorough investigation of all elements involved.

Councilman James M. Hyde, after the message was read, said certain cities in the county receive free health service from the county, and suggested that this matter be looked into, with the purpose of safeguarding the interests of Los Angeles.—Los Angeles *Times*.

* * *

Bill Calls for Premarital Tests for Venereal Disease

A bill to provide for the premarital examination of prospective brides and bridegrooms for syphilis was introduced in the Senate yesterday by Senators Edward Fletcher, San Diego, and Robert W. Kenny, Los Angeles.

Similar legislation is planned on the Assembly side. Assemblyman S. L. Heisinger, Fresno, has announced he will introduce such a measure in the Assembly and Hugh M. Burns, Fresno, anounced recently he intends to introduce a new section requiring prenatal examination of all mothers.

Certificate Needed

Fletcher said his measure would require all prospective brides and grooms to obtain a certificate showing them to be free of syphilis before the county clerk can issue a marriage license. He said restrictions on gonorrhea are not included in the bill submitted.

Senator George M. Biggar, Covello, revealed further legislation is being considered to prevent couples from evading the purpose of the act by going to a neighboring state to marry. He said the details as to how this part of the act would work have not been completed.

Any Test Acceptable

The bill already introduced makes it possible for couples to obtain certificates from any physician whom they may choose and does not limit the test to a Wassermann blood test. He said any recognized test is acceptable under provisions of the act.

The bill was referred to the Judiciary Committee for consideration.—Sacramento *Bee*, January 4, 1939.

West Virginia Requires Citizenship

The West Virginia Public Health Council recently adopted a resolution limiting the license to practice medicine and surgery in the state to native-born citizens and those who have acquired full citizenship. Each native-born citizen is to submit a birth certificate, and each foreign-born applicant a photostatic copy of his naturalization papers. At the same meeting the council adopted a resolution declaring that graduates of unclassified medical schools will not henceforth be considered for licensure either by examination or by reciprocity.—*Diplomate,* December, 1938.

* * *

Every Sixteenth Employed Person Has Government Job

One of every sixteen employed persons in the United States has a government job, according to a recent survey by the National Industrial Conference Board.

And that's not counting the army of emergency employees of the WPA and the CCC.

The Board's report shows a total of 2,590,000 men and women on regular government payrolls—federal, state and local—a new high record.

The number of government job holders has increased tremendously during the past ten years, despite great fluctuations in business and general employment.

In 1929, when general employment reached its highest level, regular government employees numbered 2,070,000. Now, although there are 4,930,000 fewer persons at work in industry, government employees total 2,590,000—a gain of 25.1 per cent. Between September, 1937, and June, 1938, about 79,000 men and women were added to regular government payrolls, while 3,340,000 had to be dropped from other payrolls.

* * *

Hospital Interest Charges Opposed

Supervisor Asks Ban on Fee System

Chairman Roger Jessup of the Board of Supervisors will demand that the County Charities Department discontinue its policy of charging 7 per cent interest on bills due for treatment at the General Hospital, the supervisor revealed last night.

"I have learned," said Mr. Jessup, "that one former patient of the General Hospital is being dunned for $59 for interest on an account due for treatment which he has been unable to pay.

"I am opposed to this. The county should not be grasping or usurious in its handling of those unfortunates who have had to resort to this institution for treatment."—Pasadena *Star-News,* December 28.

* * *

Dog Quarantine May Be Lifted

County Health Officer J. L. Pomeroy today announced he would ask that the state quarantine on dogs be rescinded.

Doctor Pomeroy's announcement followed passage by the Los Angeles County Board of Supervisors of the dog leashing ordinance which prohibits dogs from running at large except on premises of their owners. They will be required to be on a leash not more than 10 feet in length. Dogs in Altadena are affected by both the state and county regulations.

The state quarantine on dogs has been in effect almost a year and followed an epidemic of rabies now said to be under control.

It is expected that the state will accede to Doctor Pomeroy's request. This will again grant to farmers and ranchers the protection of dogs. Recently a petition from Puente Valley farmers asked modification of the quarantine so that their dogs might be left to roam as a protection for crops.

The dog leashing ordinance will not affect ranch areas but will be applicable only in more congested areas. Terms of the ordinance raise license fees for unspayed female dogs from $2 to $4, leaving other license fees as is.—Pasadena *Star-News,* December 28.

* * *

Three-Point Plan Offered for Mental Patients' Care

California must detect and attempt to cure the ills of its mental defectives in the acute rather than the chronic stages if it is to cope with the growing load of such cases, Dr. Aaron J. Rosanoff, new state director of institutions, told 600 persons at a testimonial dinner in his honor last night.

In the Hollywood Roosevelt Hotel, whose supper room was jammed to capacity with well-wishers gathered from the Siskiyous to San Diego, Doctor Rosanoff outlined his plan to ease the load on California's overcrowded and inadequate institutions for the mentally ill.

Plans Outlined

The plan has three phases, the new director explained. They are:

First, to stretch an available $4,500,000 for buildings to house patients from a proposed 3,000 beds to 4,000 beds without abandoning Class A construction.

Second, to establish a 200-bed acute neuropsychiatric unit in connection with the University of California Hospital and Medical School in San Francisco; also, later, a similar one in Los Angeles.

"With the aid of its out-patient department, such a unit would greatly facilitate the recognition of mental disorders in their incipiency and the application of appropriate treatment at a time when it often would be effective," Doctor Rosanoff said.

Extension of Care

"The final feature of my plan calls for a large-scale extension of extramural care of mental patients. At the present time about twenty-eight hundred of our state hospital patients are out on parole. These consist mostly of patients who have recovered or improved sufficiently to return to their homes and to their work."

The only way, the speaker said, that this can be accomplished is "by greatly increasing our social service personnel."

The present staff of sixteen workers would be increased to fifty-six during the new biennium, at a cost of $160,000. This, Doctor Rosanoff said, would result in a net saving of $940,000 in maintenance cost of patients during the biennium.

Doctor Rosanoff said he was assured of support from the new state administration, the personnel of his department and the interested professional groups throughout the state.

Doctor Rosanoff praised Harry Lutgens, his predecessor, for efforts during the last four years to cope with the growing mental case load. He said that the patient load increased from 18,812 four years ago to current 22,037, while the hospital capacity was growing from 14,222 to 17,555, leaving an excess hospital population of 4,482 patients.

With Dr. Lewis Browne, author and lecturer, as toastmaster, the following were introduced and spoke briefly:

Superior Judges Ben B. Lindsey and Robert H. Scott, Dorothy Wisnor Smith, head of the Travelers Aid Society; Mayor Bowron, Rabbi Edgar F. Magnin and Rt. Rev. Msgr. Thomas J. O'Dwyer.—Los Angeles *Times.*

* * *

Health Plans Views Clash *

Insurance Proposals Debated by Leaders in Medical Field

Chicago, January 25 (AP).—Conflicting views on the social aspects of medical care were voiced tonight by two leaders in the field of medicine.

Dr. Morris Fishbein, editor of the *Journal of the American Medical Association,* declared:

"America cannot exist with its medical profession enslaved to make a politicians' holiday."

Need of Middle Class

Dr. John P. Peters of Yale University—secretary of the Committee of Physicians for the Improvement of Medical Care, a group which once accused the American Medical Association of "standpatism"—asserted:

"Some method must be devised by which the great mass of our middle class population may secure the medical attention they require without being subjected to indignity."

Their addresses were delivered before the Chicago Hospital Council two days after interdepartmental committee's report—proposing compulsory health insurance among other things—was sent to Congress by President Roosevelt for careful study.

Decries Compulsion

"Compulsory sickness insurance," said Doctor Fishbein, "must inevitably result in a deterioration of the quality of medical service, and prove a step toward a fascist or communistic system."

"Compulsory insurance is damned on the basis of European experience without mention of the fact that in almost every instance it was adopted only after bitter experience with voluntary insurance," said Doctor Peters. "I admit that immediate nation-wide imposition of compulsory insurance would probably be unwise. But I have no faith at all that voluntary insurance would solve our problems."

Fears Deterioration

"We have made progress by retaining individual initiative," Doctor Fishbein maintained. "If that initiative is destroyed, progress wll cease and the dry rot and deterioration inevitably associated with job holding under political domination will set in."

"To suggest that those who receive salaries work less efficiently than those who receive fees for service is to slander 80 per cent or more of our population," said Doctor Peters. "It is a travesty upon the ideals of medicine to insist that the ceremony of direct transfer of cash from patient to physician preserves the sanctity of personal relations."

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* See also item on page 166.

Active Fight

He said organized medicine "actively combats attempts of physicians and laymen to experiment along new lines for the organization of medical services on a coöperative basis."

Doctor Fishbein reported at least three hundred experiments in group medical practice are in operation and that the vast majority of doctors participating in them are members of the American Medical Association. The Association has opposed some group plans, he added, "because in many instances they are commercialization of the practice of medicine from beginning to end."—Los Angeles *Times.*

* * *

Migrant Aid Plan Offered

"Help Them Before They Become Burdens on California," Urges Congressman

Special to The News

Washington, January 27.—A demand that the Federal Government aid "marginal people" in their home states to prevent migration to California was made in the House of Representatives this week by Representative Leland M. Ford of Los Angeles.

Representative Ford also proposed that the Government disseminate information at the sources of the migration that there will be no relief available to nonresidents of California, and that the Government encourage and aid the return to their homes of the idle thousands now in California who have neither lost legal residence at home nor achieved it in California.

He urged the Government to "recognize the inequality of having California or other states pay for these people who have come into their respective states from the outside and should transfer the money that is granted for relief to the states to which these people have moved."

He said the Government should equalize the benefits of aid to the aged so as not to make those states which are paying such benefits pay all migrants from those states which are not.

"It is the opinion of people of California that relief money should follow migration," said Representative Ford. "It is my opinion that if the tax load becomes so heavy in this or any other state it becomes uneconomical to carry on any business, to own homes or own property; that there is nothing but failure ahead."—San Francisco *News.*

* * *

Old Age Pay Rises for State

Sacramento, January 30 (INS).—Old-age assistance checks were distributed among 125,270 pension-eligible California residents and totaled $4,062,914.67 during December, Mrs. Florence L. Turner, state director of social welfare, announced today. This was an average of $32.43 for each aged recipient, compared with a November state average of $32.41.

County totals and individuals benefited included:

Los Angeles, $1,633,490.15, distributed among 50,646; San Francisco, $300,808.50, among 9,161; Alameda, $237,585.16, among 7,593; Marin, $18,431.32, among 576; San Mateo, $28,544, among 879; Santa Clara, $110,587.43, among 3,431; Sonoma, $63,586.64, among 1,982; Santa Clara County, 101,478 checks, $842,489.73; San Jose, 94,938, $784,434.22; Palo Alto, 6,540, $58,055.41; Vallejo, 7,606 checks, $67,413.87, and Santa Rosa, 8,020, $72,298.07.—San Francisco *Call-Bulletin.*

* * *

Politicus Looks Over Sacramento*

Sacramento, January 30.—In case you're interested in legislative statistics, here are a few for you:

In the Assembly, during the twenty-three-day session, there were introduced 2,767 bills, 71 constitutional amendments, 16 concurrent resolutions and 19 joint resolutions—2,873 separate pieces of legislation.

This compared to the all-time high of the lower house in 1937 of 2,785 bills, 44 constitutional amendments, 23 concurrent resolutions and 26 joint resolutions—2,878 separate pieces of legislation.

In the Senate, an all-time high was established with 1,272 pieces of legislation, being 1,227 bills, 23 constitutional amendments, 9 concurrent resolutions and 13 joint resolutions.

All-Time High for Bills

Together, both houses set an all-time high for introduction of legislation with a total of 4,155. In 1937, the entire session saw 4,071 measures introduced.

The 4,155 figure does not represent the session. When the Legislature convenes March 6, each legislator is permitted to introduce two bills, a total of 240. Each is also permitted to introduce as many resolutions as he desires.

One interesting point of the period is that ninety-constitutional amendments were suggested.

If all these were approved by both houses, it would mean a ballot containing at least ninety-four separate propositions in November, 1940, when a new President will be selected for the United States.—San Francisco *Call-Bulletin.*

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Fair Enough*†

Congress Doesn't Know Its Own Power Under Income Tax Law

New York, January 30.—The income tax amendment is short and wide. It just says that Congress shall have power to lay and collect taxes on incomes, from whatever source derived, without apportionment among the several states and without regard to any census or enumeration.

It says nothing about rates of tax or exemptions, nothing about deductions or expenses incurred in the acquirement of the income, nothing about gross or net or any fine distinction between capital and income or the subtraction from the gross of amounts paid as taxes in other ways. It says nothing about immunity for public employess of the states and their subdivisions or for labor unions or religious or charitable organizations. The amendment left all such matters to the conscience and mood of Congress in the future, and it must be admitted that, in some ways, Congress has done quite the handsome thing up to now. The courts also have done their bit.

A city man gets an exemption for himself and wife, if any, children, if any, and other dependent relatives, if any, and a farmer may also charge off the cost of supporting his cow provided she is a professional cow, producing milk, butter and, occasionally, veal, which, being sold, produces income.

* * *

May Deduct Veterinary Costs

He may even deduct the cost of a veterinary to attend his cow in her hour, although the cost of medical care for his wife, in hers, is not deductible. If the horse that pulls his plow comes down of a misery he may charge off medical advice and care and liniment, although if he, himself, comes down of a crick from pushing the plow and needs a doctor and a bottle of No. 97 or No. 38 that expense is not deductible. He may charge off wear and tear on the cow and horse but not wear and tear on himself.

If a man is a professional ballplayer—a Babe Ruth or a Dizzy Dean, for example—he is entitled to the conventional exemptions and deductions pertaining to his line of work but is not allowed to charge depreciation on his equipment, plant or whatever you would call his physique. But the corporation which owns him, as property, may list him—or, rather his contract—in the same general category as the farmer's professional or income-producing cow and show gradual depreciation and schedule as business expense the cost of pulling his teeth or tonsils, feeding him T-bones and hashed brown potatoes and shipping and stabling him on the road.

* * *

Beautiful Exhibition of Restraint

The exceptions, exemptions and immunities provided by Congress in an effort to be nice, although armed with a devastating authority to tax, are, on the whole, a beautiful exhibition of restraint, adorned by many amusing and cheering oddities.

All that the Constitution says about freedom or religion is this: "Congress shall make no law respecting an establishment of religion or prohibiting the free exercise thereof." It doesn't say that religious organizations must be immune from the theory behind chain store taxation applying to concerns operating interstate. And the income tax amendment doesn't say that Congress must permit those who contribute to religious organizations to deduct such gifts or any proportion of them from their income.

The religious freedom article doesn't even mention the subject of immunity from property taxes for religious organizations, and, of course, labor unions or pools of wealth were unheard of at that time.

* * *

Labor Unions Not Limited

However, under the income tax amendment, Congress still has the power to lay the tax against religious and labor organizations, and for all that any other constitutional provision says to the contrary, Congress may. In fact, in the paragraph of the Revenue Act, providing exemption for religious organizations, Congress bared a fang in 1936 and a phrase was inserted to provide that such organizations could not enjoy the exemption if a "substantial part" of their activities consisted of carrying on propaganda or otherwise attempting to influence legislation.

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* By Politicus.

* By Westbrook Pegler.

† Of interest, because the California Medical Association, formerly exempt as a nonprofit scientific organization, has recently been placed under a new classification, namely, a "business league," and, as such, liable for taxation.

Labor unions, however, are not placed under any such limitation, and a union under communistic domination may attempt to influence legislation without risk, whereas, nominally, at least, a church invites the wrath of the Internal Revenue for attempting to exert a counter influence.

There is almost no limit to the tricks that a playful Congress could do with the income tax authority, and if the subjects were really smart they wouldn't say a word for fear of riling the statesmen and reminding them of their strength. Under their power they can just say to Hell with cute distinctions and exemptions, and hereafter everybody, including churches, unions and all, must shower down 20 per cent or 50 per cent of all dough or profit acquired in the year, and don't forget what happened to Al Capone.—San Francisco *News,* January 30, 1939.

* * *

Chiropractors for Births Case Issue

The question of whether chiropractors may legally act as doctors at childbirth under the California Medical Practice Act was an issue today in Judge Newcomb Condee's court, where a jury was being selected to try David C. Long, 1652 West Forty-seventh Street, for violation of the Act.

He is specifically charged by Deputy City Attorney Everett Leighton of delivering a child for Mrs. Wilton Whitehouse of 1224 West Slauson Avenue. The prosecution contends that chiropractors are not allowed to use instruments, and that obstetrical cases necessarily involve their use.

Defense Attorney Max Gilmore, who has subpoenaed thirty-five physicians and surgeons, contends that under a Chiropractic Act passed in 1922, such doctors are legally empowered to attend maternity cases.

Outcome of the case will affect some four thousand chiropractors in California, it is said.—Los Angeles *Herald and Express,* January 17, 1939.

LETTERS

Subject: Hospitals of the Golden Gate International Exposition.

San Francisco, December 27, 1938.

To the Editor:—I thank you for the clipping telling of the New York World Fair medical department. . . .

The Golden Gate International Exposition will probably have two emergency hospitals, and inasmuch as the longest haul then would be one-third of a mile to either one, the ground would seem to be better covered than the New York Fair with five as they are providing for—or six that Doctor Hoguet mentions. Inasmuch as the crowd at the New York Fair will be more dense, and ambulance transportation correspondingly delayed, I believe we will have better service at the Golden Gate International Exposition. . . .

Sincerely yours,
M. R. Gibbons, M. D.,
Medical Director.

Subject: Endorsement of the "California Physicians' Service."

(copy)

Santa Clara County Medical Society
Medico-Dental Building
San Jose, California,
December 29, 1938.

The Council of the California Medical Association,
450 Sutter Street,
San Francisco, California.

Dear Doctors:

The Santa Clara County Medical Society, by unanimous vote at its regular meeting December 21, 1938, approved and whole-heartedly endorsed the plan for medical and hospital insurance as it was finally accepted by the House of Delegates at the special session held December 17, 1938, in Los Angeles. This action was taken only after mature discussion, and its unanimity is a real measure of the considered opinion of the Society as a whole.

You are informed of this action at the direction of the Society in the belief that an expression of the solidarity of this Society and the very real desire of its members to coöperate may be of interest and value to you.

By order of the Society.

Leslie B. Magoon, M. D.,
Secretary.

Subject: Medical and Osteopathic Practice Acts of California: Report of a Case.

(copy)

420 State Office Building,
Sacramento, California,
December 16, 1938.

Yours of November 26
Re: ————, M. D.

To the American Medical Association,
535 North Dearborn Street,
Chicago, Illinois.

Gentlemen:

Our records show that a letter from the Board of Osteopathic Examiners, dated April 26, 1938, signed ————, D. O., Secretary, reports that "————, D. O., was issued a physicians and surgeons' certificate (20 C. D. 5, dated July 15, 1937) by our Board on the basis of record of military service, documentary evidence of which was presented. He qualified in his application before the Board as a graduate of the Boston Institute of Osteopathy (September 10, 1900), which later became the Massachusetts College of Osteopathy."

Our records show that Doctor ———— graduated from the University of Pennsylvania School of Medicine June 8, 1898; filed California reciprocity application March 4, 1935, based upon a New York license dated September 20, 1912. On March 13, 1935, he passed the oral examination, and on March 21, 1935, was issued California physicians and surgeons' license No. C-5661 by the Board of Medical Examiners.

The above record indicates that Doctor ———— is well supplied with California licenses, *i. e.,* he holds a physicians and surgeons' license issued by the Board of Medical Examiners of this state, as well as a physicians and surgeons' license issued by the Board of Osteopathic Examiners, created under the Initiative Act of 1922. The osteopathic Initiative Act provides that on and after the effective date of said Act, the Board of Medical Examiners shall have no jurisdiction over graduates of osteopathic schools which may be licensed on the effective date of said initiative or may thereafter be licensed.

The case of Doctor ———— involves a delicate legal point. However, it is the opinion of the undersigned that Doctor ———— has, under the provisions of said initiative, automatically forfeited his physicians and surgeons' license issued by the Board of Medical Examiners, such forfeiture being based upon his having applied for and having been granted a physicians and surgeons' certificate based upon osteopathic credentials. At all events, Doctor ————'s California physicians and surgeons' license issued by the Board of Medical Examiners has been automatically forfeited through failure to pay the annual registration fee due January 1, 1938, and delinquent sixty days thereafter.

The Osteopathic Board reports his present address to be ———— Avenue, Glendale, California.

Very truly yours,
C. B. Pinkham, M. D.,
Secretary-Treasurer.

Subject: American Congress on Obstetrics and Gynecology.

An American Congress on Obstetrics and Gynecology was proposed by the Central Association of Obstetricians and Gynecologists to study our present-day problems on obstetrics and gynecology and their solution.

National, sectional, and local societies of obstetrics and gynecology have passed resolutions approving such a congress. Representatives of these societies petitioned the American Committee on Maternal Welfare, Inc., of which Dr. Fred L. Adair is chairman, to sponsor the meeting. This committee accepted the responsibility and decided to hold the meeting in Cleveland, Ohio, September 11-15, 1939. The major committees have been appointed and are now planning the program and the organization. Purposes are:

To present a program of our present-day medical, nursing, and health problems from a scientific, practical, educational, and economic viewpoint so far as they relate to human reproduction and maternal and neonatal care. The program and exhibits will be presented in such a manner that they will be of value not only to the medical profession but to nurses and all persons and agencies concerned with the problems of human reproduction and maternal and neonatal care, as well as to the lay groups.

This is not in any sense a legislative body and will take no action relative to maternal and infant care. Its purpose is, as clearly stated, a congress for the presentation of scientific material mostly of factual type. It is hoped that this will lead to better understanding among professional groups of the problems involved in human reproduction and to a better understanding and coördination of effort among the groups who are participating in the Congress.

MEDICAL JURISPRUDENCE†

By Hartley F. Peart, Esq.
San Francisco

Statute of Limitations in Malpractice Actions: Recent California Decision Further Extending Time Within Which Patient May Sue

Some time ago we commented (California and Western Medicine, March, 1937, page 204) upon the decision of the California Supreme Court in *Huysman* vs. *Kirsch*, 6 Cal. (2d) 302, in which it was held that the one-year period within which a malpractice action may be commenced is extended in the case of failure of a surgeon to remove a sponge placed in a surgical wound during surgery until one year after the patient had been informed of the presence of the foreign substance in his or her body.

A very recent decision of the District Court of Appeal, *Trombley* vs. *Kolts*, 95 Cal. App. Dec. 632, apparently further extends the exception to the one-year statute of limitations above noted. In the *Trombley* case the facts were as follows: Plaintiff was operated upon by defendant on February 12, 1932, and during this surgical operation defendant, in some manner not disclosed, allowed a skin clip to drop or fall and become embedded in plaintiff's body. In November, 1932, and on the advice of defendant, plaintiff caused x-ray films to be taken, which disclosed the presence of a foreign body, *viz.*, the skin clip. Upon being informed of the presence of the skin clip, plaintiff returned to defendant, who advised her that the skin clip would have no ill effect or detriment and that she would not thereafter be caused any trouble, injury or ill effect by reason thereof. Plaintiff testified that she believed defendant's advice and did nothing further about the matter until October 12, 1934, at which time she consulted another physician, who advised her that the skin clip, if allowed to remain in her body, would have deleterious effects upon her health. Later, in the month of October, 1934, an operation was performed by a physician other than defendant and the skin clip removed. Plaintiff's action for malpractice was commenced within one year after October 12, 1934, but of course much more than one year after February 12, 1932, the date of the first surgical operation, and much more than one year after plaintiff was *informed* of the presence of the skin clip in her body by the radiologist, who interpreted the x-ray films.

On these facts the defendant physician pleaded the statute of limitations contending that the one-year period in which a patient may commence action for malpractice started to run upon the date that plaintiff became aware of the presence of the skin clip in her body, *viz.*, in the month of November, 1932. The trial court accepted defendant's view of the case and ordered judgment in favor of defendant on the ground that the statute of limitations had run prior to the commencement of the action.

On appeal, the judgment was reversed on the ground that the statute of limitations did not commence to run until September, 1934, that is, less than one year prior to the commencement of the action. September, 1934, was taken as the date of the commencement of the one-year period by the District Court of Appeal because that was the month in which plaintiff discharged defendant as her physician and sought medical advice elsewhere. The theory of the Appellate Court was that plaintiff's cause of action did not accrue even when she was informed of the presence of the skin clip in November, 1932, so long as defendant remained her physician and caused her to believe that nothing injurious would result from the presence of the skin clip in her body.

The following quotation from the opinion of the Court discloses the reasoning upon which the decision is based:

> Upon this state of the record, showing as it does a continuation of the relationship of physician and patient, there was a continuing obligation on the part of respondent physician, and the statute of limitations did not commence to run until the termination of the relationship, which, according to appellant's testimony, occurred in September, 1934. In the instant action, the negligence consisted in leaving the skin clip in the body of appellant after the purpose for which it had been placed there had been fully accomplished, and this negligence continued up to the time of its removal in September, 1934. Where the tort is continuing, the right of action is also continuing. It was the ever-present duty of respondent doctor to remove the skin clip from the body of appellant, and especially was this his duty after he discovered from the x-rays the presence of such foreign object within the body of appellant. The evil consequences which followed the operation in the instant case gave rise to appellant's cause of action, and that cause of action extended during the entire period the surgeon was in charge of the case, and her right of action became complete only when in September, 1934, she terminated the relationship of physician and patient and sought the aid of other surgeons to remove the skin clip. It would be inconsistent to say that the appellant might sue for her injuries while the respondent doctor was still in charge of the case and advising and assuring her not to worry about the skin clip "because it will never cause you any trouble. There are hundreds of people walking around with those things inside of them and it never causes them trouble. And as your physician and surgeon, I advise you against the operation."
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> . . . The relation of employment in this case, according to appellant's testimony, having continued up to September, 1934, each day's failure to remove the skin clip was a fresh breach of the contract implied by the law. The removal of the skin clip was a part of the operation, and in this respect the surgeon left the operation uncompleted. (See *Akridge* vs. *Noble*, 114 Ga. 949, 41 S. E. 78.) Certainly, the statute of limitations should not run against appellant's rights during the time she was in ignorance of the cause of her disability, and could not with reasonable care and diligence ascertain such cause, and in the instant case, where, as she testified, appellant relied upon respondent's assurances that the presence of the skin clip would not impair her health, the statute should be tolled during all the time she was under the care of respondent and consulted only with him with reference to the condition produced by the presence of the skin clip in her body.

It is to be noted that the physician-patient relationship remained between plaintiff and defendant even after discovery of the foreign substance in plaintiff's body and that the physician defendant induced plaintiff not to do anything about it by asserting that nothing was wrong. It may safely be assumed that the Court would have held the statute of limitations to have run and the action barred if the defendant physician, upon the discovery of the skin clip, had *not* undertaken to give further advice to the plaintiff but had recommended the employment of a consultant and the submission of the matter for decision to the consultant chosen. A resort to independent advice and the furnishing of that independent advice to the plaintiff-patient, would probably have accrued the plaintiff's cause of action and started the one-year period within which action for malpractice could be commenced.

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† Editor's Note.—This department of California and Western Medicine, presenting copy submitted by Hartley F. Peart, Esq., will contain excerpts from and syllabi of recent decisions and analyses of legal points and procedures of interest to the profession.

SPECIAL ARTICLES

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CLASS AND MASS ISSUE IN SOCIAL MEDICINE SEEN*

It is the history and tradition of the medical profession—recognized by President Roosevelt in his message to the National Health Conference at its meeting in Washington—that it stands ready at all times to give of its utmost in raising the standards of medical education and the quality of medical service, and in extending the benefits of its knowledge to all who require them.

Need I repeat the now well-recognized fact that each day the physicians of this country contribute more than $1,000,000 in medical services to the people, a staggering total of $365,000,000 a year in voluntarily contributed service?

LOCAL INADEQUACIES

Nevertheless, our own studies of medical care have revealed certain local inadequacies and certain inequalities in the distribution of medical care, and we welcome the concern shown in the endeavor to solve these problems.

In discussions of this subject published during the last few years, the medical profession constantly has maintained the importance of sustaining the quality of medical care. It also has emphasized certain principles which the House of Delegates of the American Medical Association has established as fundamental to good medical service to all the people.

There can be no acceptance by the medical profession of any system of medical care which is based on the idea that the well-to-do shall receive one quality of medical care while the farmer, the laborer, and the white-collar worker are to be placated with a wider distribution of an inferior medical service.

Since experimentation is the very basis of medical progress, the physician is likely to wish for a controlled experiment suitably confirmed before he will accept either the safety or usefulness of any measure or method.

History will show that the great progress of medicine has been accomplished by this procedure and by this procedure alone.

One of the most debatable topics in social medical discussions concerns the availability of general hospital services in rural and sparsely settled areas.

ALL NEAR HOSPITALS

Spot maps, developed by the American Medical Association's Council on Medical Education and Hospitals, reveal only thirteen counties in the United States which are more than thirty miles distant from an acceptable general hospital.

There can be little disagreement on certain fundamental objectives in regard to medical care. The medical profession agrees with all other agencies on the importance of the following objectives:

The provision of good medical care for all the people; development of comprehensive preventive and public health services; development of appropriate measures to combat specific health problems, and a continuous, orderly improvement of the distribution of medical services and hospital facilities, both by geographical and economic divisions.

OTHER UNFILLED NEEDS

The medical profession would be the last to deny the existence of medical needs in the United States.

The profession, however, cannot be blind to the fact that there are other unfilled needs, especially such as relate to food, clothing, and housing, which are often as essential to health preservation as is medical care.

I think it is important to realize the historic fact that every board of health, every medical school, every hospital and every other agency which has to do with the diagnosis, prevention and cure of disease has been organized as a direct result of medical leadership.

Those people who think they can devise a centrally controlled medical service plan which can be fitted to the varying conditions of the states, counties, and cities of this country are discussing theories which no practical health administrator possibly could approve.—Los Angeles *Examiner,* January 22, 1939.

CALIFORNIA AGRICULTURAL WORKERS HEALTH AND MEDICAL ASSOCIATION

I have served as Medical Advisor * to the Agricultural Workers Health and Medical Association for a little over a month, and I find that there is a rather wide failure in understanding our purpose and our limitations, particularly our limitations.

Primarily, this organization was formed to give necessary treatment of acute and emergency medical needs in this migrant group, and their immediate dependents. This was expanded to include the care of such chronic conditions, which in a state of progress, were decreasing the earning capacity of the worker and jeopardizing his physical welfare. This was necessarily again expanded to take care of such chronic conditions in dependents as had become secondarily an emergent condition.

I sincerely believe that if the doctor will review this statement carefully and give it careful consideration when seeing these migrants, our major difficulty of misunderstanding will be solved.

We would like, as a humanitarian move, to broaden our scope and care for the obvious medical needs, but unfortunately we have to draw a somewhat arbitrary line between needs and necessity.

This division is an economic necessity, for our financial allotment is too limited for us to be philanthropic.

Let me cite for examples, three very obvious needs which confront us and in which we have to try to pick out the truly necessary with our limited knowledge of the individual cases.

Literally, thousands of these children need tonsillectomies. With years of malnutrition, exposure and repeated illnesses, chronic hypertrophic tonsillitis and adenoid hypertrophy is the rule. If we approved operation on all of these, I am sure the bill for this item alone would bankrupt the organization. We must, therefore, limit approvals to such cases as have by complications become an absolute necessity. Unfortunately others will develop complications and become necessities, but we cannot foresee these individual cases.

The same conditions prevail in the mothers in this group. With poor obstetrical care, often no obstetrical care, a very large number of these women need cervical and perineal repairs and complex laparotomy operations. Again we are forced to desert the needy and favor the urgent necessity.

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* By Irvin Abell, M. D., President, American Medical Association.

* By Edwin R. Scarboro, M. D.

Visual disturbances, correctable by glasses, offer a grave problem. We are trying to be liberal with the children of school age and have to refuse such aid to many adults, because the true necessity does not exist, as affecting employment.

We could cite dozens of similar conditions, but these three will serve. Unfortunately perhaps, there must be some central control attempting to keep these needs and necessities differentiated. Each individual physician is inclined to form his own opinion between these two, resulting often in a considerable shift to the right or the left as the case may be, hence the necessity of a Medical Director, trying to evaluate these and giving a fair division. I expect a wide diversity of opinion, perhaps accusations of unfairness, but I assure you that I am sincere and am trying to look justly on the whole problem.

The tentative fee schedule is incomplete and will need adjustments. We have tried to adjust it as a reasonable compensation for an indigent class and hope that you will accept it on this basis.

With time, there will be many problems and adjustments, and we hope that the necessary services can be rendered and that doctors can feel that they are satisfactorily, if not adequately, compensated for their efforts.

AMERICAN MEDICAL ASSOCIATION ACTION RAISES BASIC ISSUE*

Socialized Medicine, Doctors Charge, Is Government Aim

Washington, December 24.—The indictment here this week for alleged violation of the antitrust laws of the American Medical Association and two constituent bodies has brought into the public eye probably the most powerful professional society in America—one exercising almost as strong influence over its field as ever the medieval guilds did over theirs.

The action turns on the alleged unlawful activities of the Association and the constituent medical societies of the District and of Harris County, Texas, in restraining the functioning of the Group Health Association, Inc., a medical coöperative organization of Government workers.

American Medical Association leaders assert that the activities complained of are designed solely to maintain the high standards of medical practice deemed necessary to protect the health of the American people, but the Government charges that the Association has used its great powers to force its own economic interests on physicians, hospitals, and patients alike.

COERCION CHARGED

It has done this, it is charged, by causing the expulsion from its constituent bodies of one doctor taking employment with the Group Health Association; by "coercing" another doctor to leave such employment; by inducing and seeking to induce local hospitals to refuse hospital privileges to Group Health Association physicians, and by various other coercive acts, all designed to block competition by the Group Association in the provision of medical care.

Back of the action, in the opinions voiced by members of the medical society, is an effort by the Administration to force acceptance by the medical profession of so-called "socialized medicine," and particularly of compulsory health insurance. And the physicians, holding that they cannot be charged with conspiracy to restrain trade because they are not in trade but in a learned profession, declare that they will fight the indictment to the Supreme Court if necessary.

There are indications, however, that the profession is revising its stand on some of the broader aspects of the conflict involved. Powerful as is the medical association, and as sternly as it had previously set its face against governmental or group interposition into the medical field, it has modified its position greatly in the last few months.

Thus, following charges made at the Government's Interdepartmental Health Conference here last fall that the private profession was not providing medical care for lower-income and submerged groups, the Association offered its coöperation in studying and meeting this problem. And within the last few weeks several constituent local and state medical societies have announced their own plans for group medical care on an insurance or prepayment basis.

QUESTION FOR FUTURE

Whether the Association and its constituent bodies will desist from the alleged coercive tactics—alleged to be widespread around the country—against other group health associations in the face of the present suit remains to be seen. But there is no doubt, if the Association believes it can win its suit and therefore determines to stick to these tactics, that it has strong weapons at its command.

The long indictment recites many of these.

The Association, which was formed in the middle of the last century, although not to become a close-knit organization until early in the present one, includes in its membership about 110,000 of the 145,000 practicing physicians of the country, the indictment says. Those not belonging are mostly physicians employed by governmental and private agencies and not in private practice, it is said.

The Association also has a powerful magazine, and the receipts from subscriptions, together with fellowship dues, are said to amount to several million dollars a year. The indictment makes a particular point of the charge that the Association journal, the authoritative medical organ of the country, never has been open to advocates of group medicine, although it has been asserted by Assistant Attorney General Thurman Arnold that many Association members favor such policies.

ATTITUDE OF ASSOCIATION

There is no denial from spokesmen of the Association—so far at least—that it has taken the position against group medicine of which it is accused. Rather, these spokesmen turn to the code of ethics of the Society for full justification of such action.

The essential section of this code bearing on the issue is the one asserting that it is unprofessional for a physician to dispose of his services under conditions which make it impossible for him to give adequate service and to maintain reasonable competition among practitioners.

The view behind this is that if one lay group, corporate or otherwise, enters the field of providing medical care, no matter whether on a prepayment basis or not, other groups are bound to enter the same field, creating a price competition for patients which is bound to lessen the quality of service rendered.

Another objection cited to group medicine is that it involves solicitation of patients, directly or indirectly, underbidding by physicians to get contracts to serve the group, and sometimes the receipt of profit by a lay group from the practice of medicine.

All or most of these alleged evils are held inherent in "socialized medicine" and against them the medical fraternity is pictured as determined to fight to the last ditch with the great strength of the American Medical Association.

The indictment asserts that a local medical society, by threat of discipline of a member patronizing a hospital recalcitrant to its views, can deprive a hospital of the medical staff necessary to its operation. It asserts that by expelling a member the Society can close the doors of coöperating hospitals to him and his patients.

TWO SIDES CONFIDENT

As to the outcome of the suit, the Association attorneys express confidence that it is entirely in the clear, on the ground stated that medical practice is not trade and, therefore, cannot be restrained. But from the other side it is argued that operation of a hospital is not a "learned profession," that in many cases it is entirely a private business and that in the alleged coercion of these hospitals the medical association has clearly acted in restraint of trade and free competition.—New York *Times,* December 25, 1938.

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* By Frederick P. Barkley.

IN RE: COMMUNICATION FROM "THE COMMITTEE OF PHYSICIANS"*

This Committee on Medical Economics of the Medical Society of Virginia has received from Dr. John P. Peters, Secretary, a copy of certain principles and proposals on the subject of medical care. This document emanated from a group styling themselves the "Committee of Physicians." These principles and proposals were submitted for the consideration of the Medical Society of Virginia and are herewith reproduced together with comments of your committee on each item.

PRINCIPLES

1. That the health of the people is a direct concern of the government.

Comment.—We accept this only as pertaining to the care of the indigent, to the treatment of individuals whose illness constitutes a public menace, and to measures directed to the prevention of disease. We further stipulate the relative priority of the several governmental divisions; namely, local, state, and federal, in the order named.

2. That a national public health policy directed toward all groups of the population should be formulated.

Comment.—This statement needs further elucidation. If it is to be interpreted literally, it would mean the intrusion of agents of the federal government into the daily lives of everyone.

3. That the problem of economic need and the problem of providing adequate medical care are not identical and may require different approaches for their solution.

Comment.—This statement is accepted as being essentially correct, although solution of the economic problem would indirectly solve a large part of the problem of medical need. The incidence of disease rapidly increases as we go down the economic scale.

4. That in the provision of adequate medical care for the population four agencies are concerned: voluntary agencies, local, state and federal governments.

Comment.—This statement is obviously correct. Emphasis, however, should be placed on the primary position of the local government in the governmental group and on the necessity of preserving and strengthening existing voluntary agencies.

PROPOSALS

1. That the first necessary step toward the realization of the above principles is to minimize the risk of illness by prevention.

Comment.—The principle involved here has nowhere been disputed. Unwise methods have and will be opposed. The economic factor is here of paramount importance.

2. That an immediate problem is provision of adequate medical care for the medically indigent, the cost to be met from public funds (local and/or state and/or federal).

Comment.—This is largely a local problem and the degree of efficiency in medical service varies widely. Except in pauper communities, the cost should be met by the local government. Careful provision must be made to include in this group only those who are actually indigent. Pauperization of large groups of our population carries with it evils as definite and as disastrous to national welfare as do certain deficiencies in medical care.

3. That public funds should be made available for the support of medical education and for studies, investigations and procedures for raising the standards of medical practice. If this is not provided for, the provisions of adequate medical care may prove impossible.

Comment.—The intrusion of the Federal Government into the field of medical education is objectionable and can only lead to political control. This is in no way comparable to state-supported medical departments in state universities. It should also be emphasized that other factors besides a free flow of funds are concerned in the problem of raising the standards of medical practice and in promoting medical education.

4. That public funds should be available for medical research as essential for high standards of practice in both preventive and curative medicine.

Comment.—This may be agreed to provided it does not involve federal subsidy and consequent control of voluntary agencies now operating. Federal funds cannot be accepted without sacrificing an agency's fundamental independence.

5. That public funds should be made available to hospitals that render service to the medically indigent and for laboratory and diagnostic and consultative services.

Comment.—This can be accepted in principle with the provision that these funds be largely furnished by the local government. Federal grants would tend to build up certain favored medical centers and would be dictated by political consideration rather than by actual needs.

6. That in allocation of public funds existing private institutions should be utilized to the largest possible extent and that they may receive support so long as their service is in consonance with the above principles.

Comment.—Voluntary institutions should certainly be utilized to the fullest. In order to pass on the merit of this proposal, detailed information as to the plan should be available. It is absolutely necessary to preserve the independence of the voluntary institution and political control must be avoided. It is worthy of note that the Federal Government failed to follow this principle in providing medical care for veterans. That their independence can be preserved on the basis of federal subsidy is doubtful. One must be possessed of a childlike simplicity to believe that in distributing large sums to voluntary institutions the determining consideration would be the institutions' needs and their scientific efficiency.

7. That public health services, federal, state and local, should be extended by evolutionary process.

Comment.—This proposal can be agreed to provided the order is reversed to local, state, and federal, and provided the public health service be restricted to its proper field of prevention.

8. That the investigation and planning of the measures proposed and their ultimate direction should be assigned to experts.

Comment.—Investigation and planning by experts is desirable if these experts are drawn from the ranks of those who have gained familiarity with medical needs by actual experience. Direction of such a varied program cannot safely be centered in one group. The principle of local control should be maintained.

9. That the adequate administration and supervision of the health functions of the government, as implied in the above proposals, necessitates in our opinion a functional consolidation of all federal health and medical activities, preferably under a separate department.

Comment.—We see no necessity or advantage in a federal department of health. There would be a grave danger of political and partisan control of such a department, especially if its activities were widened to any such extent as has been advocated. To place $850,000,000 annually in the hands of one agency, to be expended through various channels, would mean the concentration of tremendous power in that agency. Schools, research laboratories, and other beneficiaries would be anxious to secure and maintain the approval of such an agency, so that there would be a prompt and uninterrupted flow of funds into their treasuries. Anyone who believes that these organizations would preserve their independence of thought and action is lacking in fundamental knowledge of human reaction.

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* Part of the report of the Committee on Medical Economics of the Medical Society of Virginia, that was adopted at the annual meeting of the Medical Society of Virginia, October 4-6, 1938. See also press item on page 160, second column.

Your committee feels that these principles and proposals in general tend to advocate a dangerous extention of federal control in the realm of medicine. This control may be exerted directly through additional power and authority vested by law in a federal agency, or more insiduously through the power to control the grants of subsidies to schools, hospitals, and research institutions. Many of the proposals are acceptable in principle, but are so vague and general as to the method to be pursued that they cannot properly be evaluated. They represent the views of a group who are largely engaged in institutional work and who have had little contact with the situation in the general medical field.

While we readily grant the right of any individual physician to propose and advocate any course that he may deem wise, we denounce the action of a small minority group that sets itself up to speak for American medicine.

While this committee contains the names of many physicians eminent in the teaching and laboratory field, and while we do not doubt their sincerity of purpose, we do question their fitness to pontificate on this particular subject. We know of no special source of information that they possess that is not open to every intelligent physician in the United States and their actual experience and contacts, largely limited to institutional work, do not especially qualify them as experts on the subject of their declaration. Especial eminence in one field may beget a certain arrogance of opinion on other subjects that is not actually justifiable.

These so-called "rebels" had another recourse. Over one hundred thousand physicians are organized in the American Medical Association. The objects of this organization are "to promote the art and science of medicine and the betterment of public health." Its legislative body is made up of representatives of each state and of delegates from the various sections of the scientific assembly and from the medical departments of the army, navy, and public health service. The House of Delegates of the American Medical Association is a truly representative body and it establishes and fixes the principles upon which our national organization operates. Our Board of Trustees is made up of a group of earnest and able men who are just as wise, just as experienced, and just as conscious of their obligation to society as any group that may be called together. They devote, during their term of service, a large part of their time to working out the plans and policies of our association. We feel that the proper approach of these gentlemen of the committee should have been through the channels of their local and state societies and the American Medical Association.

In support of these views, we submit the following resolutions:

Whereas, The "Committee of Physicians" has submitted to the House of Delegates of the Medical Society of Virginia certain principles and proposals on the subject of medical care; and

Whereas, The contents of this document have been reviewed and our opinions set forth in the above discussions; therefore, be it

Resolved by the House of Delegates of the Medical Society of Virginia, duly assembled at Danville, Virginia, on the 5th day of October, 1938; That we endorse this report of our Committee on Medical Economics concerning these principles and proposals; and be it further

Resolved, That a copy of these resolutions be sent to Dr. John P. Peters, Secretary, "Committee of Physicians," a copy to the Board of Trustees of the American Medical Association, and a copy to the secretary of each state medical society.

THE "IDEAL NARCOTIC"

After a nine-year quest, scientists eager to find an "ideal narcotic"—one which will control pain but not induce addiction—have reported that discovery of the drug lies in the future and that it is necessary to continue active research toward that end.

More than three hundred compounds—almost half of them morphin derivatives, the majority of which were made for the first time in connection with this work; the remainder synthetic substances—have been systematically tested. Those related to the morphin molecule that were tested on man were found to possess more or less addiction liabilities.

Results of these studies, conducted by a number of cooperating agencies having responsibility for the solution of the problem of developing some means of reducing or correcting the evils of drug addiction, were recently made known by the United States Public Health Service (Public Health Report, Supplement No. 138).

Dr. William Charles White is chairman of the Committee on Drug Addiction, Division of Medical Sciences, of the National Research Council, under whose auspices the studies were directed with funds provided by the Rockefeller Foundation. "It was recognized," said Doctor White in the report, "that the problem of drug addiction had reached a high point in international and national affairs which demanded attention, and a very considerable expenditure. It is to be remembered, however, that this problem is only a part of the far greater one of mental health, which in all its branches is probably the most serious welfare problem with which this country has to deal."

The supplement, extending to 143 pages, contains a vast amount of hitherto uncompiled data. It describes not only the chemical properties, but the method of preparation and pharmacological activities of the compounds tested. In addition to the text, there are included in tabular and other forms the chemical and structural formulae of these compounds on the basis of their chemical relationships; and complete summaries and bibliographies relating to each part of the report. At the conclusion of the book there is a list of all the publications that have been made under the direction of the Commission since its beginning. Many of these have been published in the Public Health Reports.

Divided into three sections, the report takes up first the discussion and conclusions drawn from research with 125 morphin derivatives. From these studies it is apparent that specific chemical modifications affect uniformly neither in direction nor degree all of the pharmacological actions of alkaloids of this series.

The second section discusses chemicopharmacological reactions for more than two hundred synthetic substances built upon phenathrene, dibenzofuran, and carbazole. Applied to mice, rats, rabbits, and cats, some of these synthetics, especially in the carbazole series, evidence a considerable degree of pain controlling action. All of them, however, exhibited "side actions" more or less undesirable.

The concluding section of the report reviews clinical studies made at the United States Penitentiary Annex, Fort Leavenworth, Kansas, and at the United States Public Health Service Hospital, Lexington, Kentucky. This latter section aimed especially to determine the addiction liability of some sixteen selected morphin derivatives.

This portion of the booklet reviews a working method of quantitative evaluation of the phenomena of abstinence, and discusses tolerance, habituation, and dependence with their relations to drug addiction. With the aid of a most modern encephalograph, built at the Lexington Hospital, the Public Health Service has for the first time an implement for studying the differentiating action of a series of addiction drugs of known chemical modification in the study of brain physiology. This instrument aids in overcoming impediments to the study of cerebral and other living responses of the nervous tissues, and provides a new objective technique for studying the living neuro-electric reaction.

TWENTY-FIVE YEARS AGO[†]

EXCERPTS FROM OUR STATE MEDICAL JOURNAL

Vol. XII, No. 2, February, 1914

From Some Editorial Notes:

Why Not Save the Money?—One of our advertisers is good enough to give us information in regard to specific instances wherein his advertising in your Journal does or does not pay. A customer came to his store and, noticing a certain article, remarked that he did not know they carried that; he had just bought one from an eastern house and had had to pay the same price, plus the express charges of $3.40. And that very article had been advertised in your Journal. The local dealer would have saved that member at least $3.40. Does it pay to look through the advertising pages? It would have paid that one doctor on that one purchase, $3.40; how much more he has thus foolishly spent it is impossible to say. Another definite instance where a member bought from an eastern house an article advertised in your Journal by a local dealer, is one in which the article cost the purchaser 25 per cent more than he could have bought it for right here at home. It is safe to say that members could save much more than the amount of their annual dues if they would look through the advertising pages of their Journal and purchase goods from their own advertisers. "It pays to advertise," is very true; it is also and equally true that "It pays to read advertisements!"

* * *

Suits for Damages and Their Defense.—Some of our members who have joined in the last year or so do not understand that the State Society has a legal department of the very best and that it defends its members, without cost to them other than their regular dues and assessments, in all such actions. Membership in the State Society, because of this one feature alone, is now one of the most valuable assets that a practicing physician can have. The suits which we have defended, all of them successfully, in 1913, would have cost the individual physicians sued a great many thousands of dollars—and they would not all of them have been won. Our legal department is so well up in this work and our lawyers are of such high standing that in many cases where the member has also had insurance in some company, he has requested our attorneys to take charge of his case. . . .

Could any rules be simpler? Suits are increasing rather than decreasing; there seems to be a craze to "sue the doctor"; are you protected? You do not and cannot know what day some disgruntled patient may sue you. It is much wiser to pay the few dollars a year your dues cost you than many hundreds or thousands of dollars it would cost you to defend a suit. Medical defense by the State Society is real defense; it defends.

* * *

A New Medical (?) Organ for "Slamming."—Apparently, there were not in existence enough so-called medical (?) journals living on fraudulent and deceitful advertising and so desirous of slamming the American Medical Association; a new publication has been started, but whether it will be parasitical and thrive on the nostrums is not yet certain; it is young, very young, and its circulation is bound to be small, very small. It is the journal of the American Medical Editors' Association, that highly upright and cleanly organization of which mention has been made before in the pages of the Journal. Vol. 1, No. 2, is the issue under present observation, and it contains three separate items that are intended to be deliberate slams at the Association. . . .

* * *

A Suggestion for Help.—The Santa Barbara County Medical Society publishes a printed announcement and program of meetings which is sent out to the members a week or ten days in advance. This is an excellent idea in itself, but it was not the particular thing in mind. A few months

(Continued in Front Advertising Section, Page 15)

[†] This column strives to mirror the work and aims of colleagues who bore the brunt of Association activities some twenty-five years ago. It is hoped that such presentation will be of interest to both old and new members.

BOARD OF MEDICAL EXAMINERS OF THE STATE OF CALIFORNIA[†]

By Charles B. Pinkham, M.D.
Secretary-Treasurer

News

"Unable to raise bail after it was boosted from $1,500 to $2,000 cash at a preliminary hearing before Municipal Judge Herbert C. Kaufman, Mrs. Lena Mareck, fifty-six, was jailed today on charges of performing an illegal operation in connection with the critical illness of an Oakland woman. . . . Inspector Harry Husted of the homicide detail asked that her bail be increased, pending the outcome of the condition of Mrs. Dolly Murray in Peralta Hospital in Oakland. . . . Mrs. Mareck was arrested at her home, 819 Ocean Avenue, on the request of Oakland authorities. Mrs. Mareck's son, 'Dr.' Andrew Mareck, was charged seven years ago with the murder of Mrs. Anita Lund, nurse at the Laguna Honda Home, who was found dead from the effects of a crudely performed operation. She had been beaten until her face was almost unrecognizable. Mareck was acquitted of the Lund murder after two trials, but was sentenced to San Quentin in 1933 to serve life for the murder of Special Officer William Garrick during a Santa Rosa robbery. . . ." (San Francisco *Call-Bulletin*, January 5, 1939.)

According to the San Francisco *Call-Bulletin* of January 2, 1939, former Governor Merriam made the following appointments:

Roy Labachotte, Redwood City, member, State Board of Chiropractic Examiners, vice Raymond C. Foy, term expired.

Joseph T. Stacy, Sacramento, member, State Board of Chiropractic Examiners, vice M. H. Disney, San Diego, term expired.

Selma M. Giese, Los Angeles, member, State Board of Chiropractic Examiners, vice C. O. Hunt, Oakland, term expired.

Russell C. Willett, San Francisco, member, State Board of Chiropractic Examiners, vice self, term expired.

Melville Z. Ellis, Long Beach, member, State Board of Chiropractic Examiners, vice C. E. Walker, Redding.

"A doctor is not criminally responsible for the hiring of a nurse, the appellate department of the Superior Court ruled. In a brief memorandum opinion the Court said. . . . 'At most the promise of defendant to see that the complaining witness would get paid was, in our opinion, a mere guaranty of the primary obligation of the patient to pay his nurse, and not the assumption of that primary obligation by the defendant doctor. That being so, not only was the promise unenforceable, because not in writing (C. C. 1624, sub. 2), but we do not believe that defendant falls within the class intended to be covered by Section 216 of the Labor Code.' Doctor Blank was adjudged guilty of violating Section 216 of the Labor Code by Municipal Judge Theresa Meikle on complaint of Pauline Washauer, a registered nurse, for the alleged nonpayment of wages. He was given a thirty-day suspended sentence and granted probation with the direction to pay $24, claimed to be owing to the nurse. Attorney Frank A. Flynn, on behalf of his client, contended that the doctor's attempt to see that the hospital and nurse's bills were paid did not impose any obligation upon himself, and the fact that the patient had no money did not justify criminal proceedings. It was also contended that he acted in the position of directing employment and not employing nurses." (San Diego *Transcript*, December 31, 1938.)

"A sweeping proposal to 'extend to the people of California the benefits of medical science along the same lines as educational benefits now being enjoyed,' was sent to Attorney-General U. S. Webb today in the form of an

(Continued in Front Advertising Section, Page 23)

[†] The office addresses of the California State Board of Medical Examiners are printed in the roster on advertising page 6.

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(Continued from Page 31)

episodes the field force put a greater part of its time into drug supervision than last year—33 per cent as compared with 29.4 per cent in 1937.

Reviewing briefly the five-year effort for revision of the Food and Drug Act, Mr. Campbell says that this effort "produced a measure that will unquestionably afford greatly increased public protection even if it does not contain all of the provisions its advocates have urged." A few provisions became effective immediately, but the general provisions of the new law do not supersede the old act until June 25, 1939.

In general the report follows those of previous years and includes comparative statistics of the time and effort devoted to various phases of enforcement.

One new phase of enforcement is the investigation of the reworking of returned stocks of candy. Some manufacturers have been distributing objectionable goods, but the administration was unable to act until it could perfect analytical methods that would prove convincing in court tests. A survey showed conditions were good in the great majority of plants where returned candy is reworked, but deplorably unsanitary in a few cases. "The campaign," says the report, "will be continued until interstate traffic in this type of filthy confectionary is stopped."

Maple syrup producers responded to the educational campaign of the previous year for abandonment of equipment and utensils containing lead, which may make the syrup unfit for food. Nevertheless, out of 300 samples, 22 contained too much lead and shipments were seized.

The Administration investigated about the usual number of cases of suspected food poisoning—76. As usual, no case of botulism was found that could be traced definitely to commercially canned foods.

The salmon pack was in excellent condition and no seizures were necessary, a result both of favorable weather and greatly improved conditions which canners have adopted for their own protection. Some canned tuna was detained on account of lead from containers or because of decomposition.

Under the McNary-Mapes amendment, there were 153 seizures of canned goods that failed to meet the standards of quality, condition, or fill of container.

The quality of ether was materially improved, with less than 4 per cent of the samples failing to meet requirements as compared with more than 8 per cent in 1937.

Research work was devoted to improving test procedures for biological vitamin products and drugs. Laboratory technicians are making special efforts to improve tests for the decomposition of food products.

The Administration also reports briefly developments in the enforcement of other legislation for which it is responsible—the Insecticide Act, the Caustic Poison Act, the Import Milk Act, the Tea Act, the Filled Milk Act, the Naval Stores Act, and the Certification of Coal-Tar Colors.

Cancer Research.—"More intensive work will gradually solve many of the problems still facing scientists engaged in cancer research," is the statement of Dr. Carl Voegtlin, Chief of the National Cancer Institute, after a study of thirty years of activity in that field.

A survey of the last three decades of fundamental cancer study is contained in the current issue of *Public Health Reports* (Vol. 53, No. 48). It shows that a considerable amount of knowledge concerning cancer has been acquired during that period through experimental research.

The report was formulated by a committee of outstanding scientists appointed by Dr. Thomas Parran, Surgeon General of the United States Public Health Service. The committee members were Dr. James B. Murphy and Dr. John Northrop of the Rockefeller Institute for Medical Research; Dr. Stanhope Bayne-Jones, professor of bacteriology and Dean of the School of Medicine, Yale University; Dr. Ross G. Harrison, chairman of the National Research Council and Sterling professor of biology, Yale University; Dr. Clarence C. Little, director, Roscoe B. Jackson Memorial Laboratory.

This marks the first time that efforts have been made to formulate in one plan the fundamental aspects of cancer

(Continued on Page 36)

OLEUM PERCOMORPHUM (Liquid)

10 and 50 cc. brown bottles in light-proof cartons. Not less than 60,000 vitamin A units, 8,500 vitamin D units (U.S.P.) per gram. 100 times cod liver oil* in vitamins A and D.

FOR GREATER ECONOMY, the 50 cc. size of Oleum Percomorphum is now supplied with Mead's patented Vacap-Dropper. It keeps out dust and light, is spill-proof, unbreakable, and delivers a uniform drop. The 10 cc. size of Oleum Percomorphum is still offered with the regulation type dropper.

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Uses: For the prevention and treatment of rickets, tetany, and selected cases of osteomalacia; to prevent poor dentition due to vitamin D deficiency; for pregnant and lactating women; to aid in the control of calcium-phosphorus metabolism; to promote growth in infants and children; to aid in building general resistance lowered by vitamin A deficiency; for invalids, convalescents, and persons on restricted diets; for the prevention and treatment of vitamin A deficiency states including xerophthalmia; and wherever cod liver oil is indicated.

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(Continued from Page 34)

research. In releasing the information Doctor Voegtlin stated that the committee undertook a difficult task in formulating a plan on fundamental cancer research because of the complex nature of the subject, but he felt that the comment will greatly help to clarify the facts which already have been established in this field. The report thus attempts to check and critically evaluate the results to date, as well as to suggest the lines for future activity.

The report pointed out that certain chemicals, radioactive materials, x-rays, and biological products including viruses are already known to cause cancer. What is now most needed, the committee pointed out, is work which will explain why and how these different agents produce cancer. This line of research is concerned with cell physiology. Efforts should be made to explain how these various substances and agents produce the transformation of normal cells into cancer cells. This is the crux of the cancer problem, according to the group of scientists which makes up this committee.

Another point of needed investigation, according to the report, is a study of the question of why the cancer cell behaves as it does. Research scientists are eager to know why cancer cells show such unlimited and uncontrolled growth in the body. It is yet to be determined whether this behavior of cancer cells is due to differences in chemical makeup, or to some other factors. Solution of this problem would provide in all probability the key to the real causes of cancer. The report pointed out, however, that such problems require much patience and much time for their completion.

Continued search for new methods of treatment of cancer is also urged by this report on fundamental cancer research. The matter of the routine trying out of new things which might be of use was encouraged, because sometimes this type of investigation leads to highly important results. An example along this line is the cyclotron, a new atom-smashing machine, which produces radioactive material which may possibly become of value in the treatment of cancer and other malignant diseases.

The report stresses that cancer research of the future should continue to be concerned with the relationship of heredity to this disease, and lays emphasis upon the study of different types of cancer since they are almost like different diseases. With respect to studies of heredity, the report states that "from the practical side, this general field has assumed an importance for it is probable that preventive measures will come from knowledge gained from this type of investigation."

In considering the ways and means of carrying on future studies, it was evidenced by the report that the field of experimentation with animals, principally mice, would be essential. The report states, "in this connection it has become evident that pure strains of animals of known hereditary tendencies are as important for cancer research as pure chemicals are for the chemists."

The report, furthermore, approves collaboration between the research institute and the newly established cancer clinic of the Public Health Service in Baltimore, Maryland. This coöperation is recommended with a view to detecting and utilizing clinical problems for research in the laboratory, and testing in the clinic promising methods suggested by laboratory experimentation.

The report is designed primarily to assist the Government in its program to control cancer. At the same time it points out to research workers generally and other scientists and physicians the accomplishments to date and the needs ahead. It is believed also that the report will have considerable value to organizations and individuals who may be considering the financing of projects in cancer research and treatment.

Doctor Voegtlin stated that scientists of the National Cancer Institute are already investigating some of the basic problems mentioned in the report and that after the completion of the Institute's laboratory, work will be carried forward on a broader basis and with increased vigor.

Far from being a curse, eyeglasses are indeed a blessing, without which the majority of people would be unable to cope with the demands of civilization.—*Hygeia.*

RECENT ADVANCES IN THE SCIENCE OF NUTRITION

VI. The Chemical Identification of Thiamin or Vitamin B_1

● An outstanding accomplishment of American Biochemical research has been the chemical identification—by degradation and by synthesis—of thiamin or pure vitamin B_1 (1). Thus, another dietary essential long known by its physiologic functions has been identified chemically, in this instance as a quaternary thiazole.

This discovery is of the most basic importance in the field of vitamin B_1 research. Determination of the chemical nature of this factor permits not only explanation of certain previously known facts concerning vitamin B_1, but in addition, has opened new fields of research. One of these is already concerned with the development of a reliable chemical method for estimation of thiamin which will be generally applicable to foods.

At present, quantitative determination of vitamin B_1 necessarily requires the use of one of the several bioassay methods available for that purpose. None of these is entirely satisfactory (1, 2). Perfection of a chemical method for quantitative measurement of thiamin in foods would add greatly to our knowledge of its occurrence in nature, as well as permit more comprehensive studies of factors which might influence the stability of vitamin B_1 in foods. We have a relative paucity of such data relating to vitamin B_1 when the available information on vitamin C is considered.

It should also be stated that the synthesis of thiamin—which is now produced on a commercial basis—has already provided the clinician with a most useful diagnostic tool. Administration of the pure vitamin in cases of suspected thiamin deficiency, with notation of the therapeutic response, constitutes the most trustworthy means of detecting avitaminosis B_1. After the diagnosis has been confirmed and the immediate deficiency corrected by administration of thiamin, it is desirable that future adequate supply of vitamin B_1 be obtained through dietary readjustments (1).

In this connection, commercially canned foods deserve particular mention. Nutritional research (3, 4) on various members of this class of foods has demonstrated their potential value when included in a varied diet calculated to supply optimal amounts of vitamin B_1.

AMERICAN CAN COMPANY

230 Park Avenue, New York, N. Y.

(1) 1938. J. Amer. Med. Assn. 110, 727.
(2) 1938. Ibid. 111, 927.
(3)a. 1936. J. Nutrition 11, 383.
b. 1936. J. Amer. Diet. Assn. 12, 231.
(4)a. 1932. J. Nutrition 5, 307.
b. 1932. Ind. Eng. Chem. 24, 457.

We want to make this series valuable to you, so we ask your help. Will you tell us on a post card addressed to the American Can Company, New York, N. Y., what phases of canned foods knowledge are of greatest interest to you? Your suggestions will determine the subject matter of future articles. This is the forty-fifth in a series, which summarize, for your convenience, the conclusions about canned foods reached by authorities in nutritional research.

The Seal of Acceptance denotes that the statements in this advertisement are acceptable to the Council on Foods of the American Medical Association.

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Medicine on Parade: The Medical Program for the Hall of Science, Golden Gate International Exposition.* Latest advancements in medical science, new weapons of the war on disease, and most recent methods of treatment, are demonstrated in the many amazing exhibits in the Hall of Science at the 1939 Golden Gate International Exposition on San Francisco Bay.

Believing that future medical progress depends largely upon educating the public to the advances which already have been made, a number of leading medical men have spent two years in organizing the exhibits. This "parade of medicine," however, is no ordinary recital of accomplishments, but a dramatic, confidence-inspiring display of progress with explanations of problems still unsolved. In general the exhibits emphasize the necessity of constant coöperation of a patient, actual or potential, with his physician. They show also the practical, particularly the financial, benefits of preventive medicine. Of particular importance in the matter of medical education of the layman is the honest and accurate presentation of such hitherto unmentionable subjects as cancer, venereal diseases, and the chemical factors involved in sex.

These subjects and many others are clarified for the spectator through an efficient combination of exhibits, motion pictures, and lectures. The medical leaders who gave much of their time and efforts to arrange exhibits and lectures have constantly emphasized the prophecy that if only one visitor in every hundred can learn how to avoid tuberculosis or pneumonia or cancer, the resultant benefits to the country will be felt for generations.

As part of the medical program for 1939, Dr. Milton Silverman, Exposition head of the Hall of Science, and his committee arranged a complete schedule of lectures, which are held in the auditorium of the Hall of Science. Many of the scheduled speakers are distinguished research workers or clinicians from Europe and eastern United States. Others are outstanding specialists in the great universities, hospitals, and research centers of the West Coast. All these lectures will be addressed primarily to the laymen—presented in popular language and on subjects which vitally affect his well-being. Many are directed particularly to school children. Lecture topics have been planned to harmonize with exhibits in the Hall of Science. Many of these talks will be heard over coast-to-coast radio hookups.

Realizing the tremendous importance of the moving picture in modern education, the Advisory Committee on Medicine presents hundreds of reels of moving pictures in the Hall of Science auditorium, to show the most modern, accurate information on the structure, development and workings of the human body, and on the cause, prevention and treatment of scores of important diseases. These film programs offer to the public its first opportunity to see actual details of work which is proceeding daily behind closed doors in research laboratories, clinics, and hospitals.

Many of the great medical associations of the West and of the United States developed the special programs centered around the Hall of Science.

Among these groups are the American and the California Medical Associations, the California State and American Dental Associations, the American College of Physicians, the American Association for the Advancement of Science. Many other societies are holding conventions or "special day programs" at the Exposition.

Scheduling of these programs assures Exposition visitors of outstanding lectures by the country's outstanding medical men—"talks by the men who did the work themselves."

Approximately 50,000 square feet of exhibit space—well over an acre—have been assigned to accommodate medical exhibits in the Hall of Science. After more than a year of intensive work, the director and the Advisory Committee reported that this entire section was under contract—without a single "commercialized" exhibit and without any duplication of exhibit material. A review of the Hall of Science follows:

General Medicine.—The "keynote" exhibit of the medical section, sponsored by the American Medical Association, includes material on four important fields of health work.

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*By Charles F. Berry.

First, is a display on the history of medicine and the heroes of medicine in the United States, and particularly in the countries bordering the Pacific Ocean.

Visitors will see what these countries have contributed to international health, as exemplified by the work of such men as Ephriam McDowell in surgery, William Beaumont in physiology, Crawford Long in anesthesia, Oliver Wendell Holmes in puerperal fever, J. Marion Sims in surgery, William H. Welch in gas gangrene, Theobald Smith in tick fever, Walter Reed in yellow fever, William C. Gorgas in sanitation, and Howard Ricketts in Rocky Mountain spotted fever.

The American Medical Association pays homage to a number of great western men of medicine—the California Indians, who introduced Spanish explorers to cascara and other native drugs; Petro Prat and his hospital at San Diego; Marcus Whitman, the first physician in the Pacific Northwest; the San Francisco pioneers—H. H. Toland, Levi Cooper Lane, Elias Cooper, Richard Cole, and James Blake; the Japanese bacteriologists—Kitasata and Shiga; and two great Chinese—Hua T'o, a surgeon who lived in the second century A. D., and Pien Ch'iao, who studied anesthetics seven centuries before the birth of Christ and twenty-five centuries before the discovery of ether.

A second section in this exhibit explains the various subjects involved in modern medicine and shows, by animated displays, the significance of such basic sciences as physics, chemistry, and zoölogy, and of such clinical fields as pediatrics, neurology, surgery, dermatology, urology, obstetrics, internal medicine, ophthalmology, and otolaryngology.

A third section is based on contributions of medicine to public health, and shows the various public health activities which were instituted largely by the medical profession. Here is illustrative material on communicable disease control, epidemiology of important infections, control of food handlers and food supplies, water protection, sewage disposal, health education of the public, protection of milk, vital statistics, and the like.

In the fourth section the American Medical Association deals with a novel and highly important combination—medicine and physics. Here emphasis is placed on the apparatus used in medicine, particularly in medical diagnosis. Displays range from animated explanations of the thermometer and hypodermic syringe to the x-ray apparatus and the microscope.

In charge of the entire American Medical Association display is Dr. Thomas Hull.

Dentistry.—Competing with general medical exhibits for public appreciation and coöperation is the large exhibit sponsored by the American Dental Association in conjunction with the California State Dental Association.

In this section, visitors will see dramatic exhibits of both the esthetic and clinical aspects of modern dentistry. They will see, by electrically animated displays, the influence of teeth upon appearance and upon health and efficiency. They will see the history of teeth—in exhibits on the historical relationship between teeth, diet, and facial appearance—and the history of a tooth—in an exhibit showing the anatomical and physiological development of teeth.

Dental disease and its prevention is emphasized in exhibits on dental decay, pyorrhea, and other pathological conditions. Of particular interest in this section is the "talking tooth" and its lecture on mouth hygiene. Diagnosis of dental disease is explained in a featured exhibit on x-ray diagnosis.

The progress of dentistry during the past century is outlined by a series of displays showing the appearance of a dentist's office in 1839, a similar office in 1939, and the intervening steps which account for the tremendous changes. Special exhibits on tooth straightening and tooth repair are displayed, and a question box is provided for the benefit of visitors who may desire additional information.

The dental display is under the direction of Drs. Lon Morrey of Chicago, Wilfred Robinson of Oakland, and John Leggett of San Francisco.

Surgery.—Two separate exhibits have been designed to illustrate the modern advances in surgery, and the rôle of surgeons in combating disease and disfigurement.

One is based entirely on plastic surgery, and is sponsored by the St. Francis Hospital of San Francisco. In this area is displayed the present status of this particularly dramatic subject, and the methods used by plastic surgeons. Rather than emphasize the use of plastic surgery as a type of "beauty treatment," this exhibit ignores the completely esthetic features and stresses repair of congenital and accidental disfigurement.

Special sections are devoted to the surgical repair of congenital cleft palate and harelip, burns, damaged fingers and hands, and disfigurement resulting from automobile accidents. Of particular significance to the visitor are simple explanations of the methods involved, particularly the transplanting and grafting of bone, muscle, nerve, blood vessel, fascia and other tissues from one part of the body to the other.

Dr. George Warren Pierce is in charge of the plastic surgery exhibit, with Dr. Loren Chandler of the Advisory Committee.

The chief surgical exhibit is under the sponsorship of one of the greatest medical institutions in the world, the famed Mayo Foundation of Rochester, Minnesota. This

(Continued on Next Page)

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NITRATE	0 parts per million
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(Continued from Preceding Page)

display has been especially prepared by Mayo scientists, to teach some fundamentals of human anatomy, to explain the function of certain important organs, and to describe some of the recent important discoveries which enable the physician and surgeon to cure or control disease and correct abnormalities.

As an introduction, there is first a section devoted to anatomy, with five life-size models of the human body, constructed from semitransparent materials. These show the chief organs of the body—their size, location, and relationships. Additional exhibits show "close-ups" of these organs, to explain their complicated intricacies. The action of the heart and lungs is shown in particular detail by specially constructed animated models and diagrams.

Another section of the Mayo exhibit is devoted to anesthesia, and shows particularly the modern methods of producing local anesthesia, in different parts of the body.

The major portion of the area, however, is set aside for exhibits on diseases of the gastro-intestinal tract and their treatment by surgical methods. Included are displays on operations for gastric ulcer, gastric cancer, and appendicitis.

Other sections of the exhibit house material on treatment of bladder and prostate gland diseases, thyroidectomy, and bone grafting for the treatment of fractures.

In charge of the Mayo exhibit is Dr. Arthur Bulbulian of the Mayo Foundation museum, with Doctor Chandler of the committee.

Red Cross.—Known throughout the world, but primarily for its work in first aid and emergency relief, the American National Red Cross makes its appearance in the Hall of Science as a scientific institution of high rank.

The public will see for the first time the modern research work carried out by Red Cross scientists in fighting pellagra and other nutritional diseases, in developing "blood banks" for life-saving following accidental hemorrhage, in combating typhus fever and plague, and in aiding other medical groups to adopt the newest and most modern weapons which the laboratories have produced.

In addition, the Red Cross exhibit shows new details in the more familiar work of the society—flood relief, care of sick and homeless refugees in stricken areas, erection and maintenance of emergency hospitals during epidemics, and first aid to victims of home, swimming pool and highway accidents.

The direction of the exhibit is under Dr. William DeKleine, D. H. Moore of the Red Cross, and Doctor Silverman of the committee.

Cancer.—As one of the real high spots of the entire Exposition, research workers and practicing physicians have combined their efforts to tell—for the first time in history—a modern story of the causes, diagnosis, prevention and cure of cancer.

For generations, scientists and laymen alike have been awaiting the reported discovery of the cause and cure of cancer. Yet, today, enough is known about this most mysterious of all diseases to justify a report of present status to the public.

The long-awaited information has been culled from the greatest medical research institutions in the world. It is by no means sensational in character—every detail of the exhibit has been checked by the Cancer Commission of the California Medical Association, the exhibit sponsor—but the story of the exhibit marks one of the most brilliant advances in medical history.

The exhibit has been arranged in the simplest possible form—as questions and answers. The queries include: What is cancer? What causes it? Is it inheritable? How does cancer spread and cause death? Can it be diagnosed? Can it be treated? Can it be cured? Can it be prevented?

Included in the replies are accurate, non-evasive answers, demonstrations of chemicals and physical factors which have been found to cause cancer, demonstrations of diagnostic methods, and explanations of the three types of curative procedures.

The cancer exhibit is under the direction of Drs. Alson Kilgore of the Cancer Commission, T. Henshaw Kelly of

(Continued on Page 42)

Measles Modification with

IMMUNE GLOBULIN (Human)

Lederle

FIVE YEARS OF CLINICAL STUDY and laboratory investigation of this serum have proved its value in the modification of the attack and the lessening of the dangerous complications of measles.

Two published reports[1, 2] of this study are significant. Others are in preparation. These observations indicate that as little as 2 cc., if injected intramuscularly within 6 to 8 days after the initial intimate exposure, is effective in children under 2 years of age.

Older children require larger doses.

It is believed by some authorities that 2 to 3 times the indicated modifying dose will often prevent the attack entirely.

There is no satisfactory evidence available that an attack of measles can be modified by administration of any practical dose of Immune Globulin (Human) after the characteristic symptoms of the disease have appeared.

[1] Levitas, Irving M.: Treatment, Modification and Prevention of Measles by Use of Immune Globulin (Human), J.A.M.A., 1935, *105*, 493.

[2] Laning, G. M. and Horan, T. N.: Immune Globulin Used as a Preventive and Modifier of Measles, Jour. Mich. Med. Soc., 1935, *34*, 772.

"IMMUNE GLOBULIN (Human) *Lederle*" is distributed in 2 cc. and 10 cc. multiple dose, rubber-stoppered vials.

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(Continued from Page 40)

the State Medical Association, and Milton Silverman of the Advisory Committee.

Chemicals versus Disease—Syphilis, Malaria, Streptococcus Infections.—That branch of medicine which deals with medical applications of chemicals—pharmacology—recognizes only three types of drugs which cure disease. These are the arsenicals and bismuth preparations used in treating syphilis, quinin and its derivatives used in malaria, and sulfanilamid and its derivatives used in combating streptococcus infections (childbed fever, scarlet fever, blood poisoning), meningitis, certain types of pneumonia, and gonorrhea.

In an exhibit sponsored by the Winthrop Chemical Company, the brilliant records of these drugs are presented in popular terminology.

Of particular current interest is the section devoted to syphilis. Here, emphasis is placed on the diagnostic tests and on the treatment. Other phases of syphilis are presented elsewhere (see below).

Among the methods of diagnosis, special attention is given the Wassermann test on blood and spinal fluid, and the darkfield test on suspected lesions.

Other exhibits on syphilis are devoted to the manufacture of drugs, their chemistry, their control for purity, their use in the patient, and the results of treatment. The exhibit is kept up to date by inclusion of material on the treatment of tertiary or neurosyphilis with artificial fever.

In the second section of the Winthrop exhibit, displays relate the romantic history of quinin—its first use by Peruvian Indians, its discovery by Spaniard explorers, its monopoly by the Peruvian Government and the breaking of this monopoly by European adventurers.

The exhibit brings this story up to date by describing the development of new synthetic substances, such as atebrin and plasmochin, and the control of malaria by sanitary engineering methods.

The third section tells the most modern achievements of chemotherapy—the development and use of sulfanilamid. Visitors will see how this drug was developed in European laboratories and then applied in Euprope and the United States to treat deadly streptococcus infections, meningitis, and other diseases.

The exhibit is under the direction of Dr. Martin Lasersohn of Winthrop and Dr. Leake of the committee.

Venereal Diseases.—As an addition to the Winthrop Chemical Company exhibit on chemotherapy and as a practical climax to the current fight for sane education against venereal disease, the California State Department of Health is sponsoring a large, complete display on syphilis and gonorrhea.

In this state exhibit, no mention is made of diagnosing or treating; instead, efforts of the department's workers are directed toward an exposition of the cause, the epidemiology and the results—physical, mental, and sociological—of venereal infections.

(Continued on Page 44)

S.M.A. —FOR INFANTS DEPRIVED OF BREAST MILK

When diluted according to directions, S.M.A. closely resembles human milk, *NOT ONLY* in the percentages of protein, fat, carbohydrate and ash, *BUT ALSO* in the chemical constants and in physical properties.

When fed to infants as a supplement, complement or as a complete substitute for breast milk, S.M.A. consistently produces excellent nutritional results comparable to those obtained with normal breast-fed infants.

The quick, easy method of preparing S.M.A. feedings is unusually simple. A Minute Mix Method Set together with complete directions will be sent Free to physicians on request.

S.M.A. is a food for infants . . . derived from tuberculin tested cows' milk, the fat of which is replaced by animal and vegetable fats including biologically tested cod liver oil; with the addition of milk sugar and potassium chloride; altogether forming an antirachitic food. When diluted according to directions, it is essentially similar to human milk in percentages of protein, fat, carbohydrate and ash, in chemical constants and in physical properties.

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PHYSICIANS' AND SURGEONS' TELEPHONE EXCHANGE • NURSES' BUREAU

(Continued from Page 42)

Visitors will see enlarged models of the responsible microbes, the methods whereby they destroy tissue and the way in which they spread. Carefully selected pictures illustrate the easily recognizable symptoms which mark the disease.

Additional exhibits show the damage which venereal diseases do to the patient body, his mental processes, and his community. Visitors will learn that future control of these infections depends almost entirely on proper public appreciation and use of methods and drugs which are already available.

This exhibit is under the direction of Drs. Walter Dickie and Malcolm Merrill.

Heart Disease.—As number one killer in the United States, heart disease deserves and is given prominence in the medical section. Under the sponsorship of Ciba Pharmaceutical Products of Switzerland, a complete display is presented on the structure and function of the heart, and on the causes, diagnosis and relief of heart disease.

Featured in this exhibit are a five-foot transparent model of a constantly beating heart, an animated display showing the route of blood flow through the body, and the use of such diagnostic procedures as fluoroscopy, blood-pressure readings, and electrocardiography.

Other sections include informative material on the composition of the blood, the pump action of the heart, high blood pressure, and the use of chemicals in treating heart disease.

The exhibit is under the direction of Mr. A. Douglass Brewer of Ciba and Doctor Dock of the committee.

Tuberculosis.—Under the sponsorship of the California Tuberculosis Association, recent advances in the fight against the "white plague" are reported to the public.

Of most significance is the announcement that tuberculosis has now become most dangerous in the high school and college group. Recent investigations show a startling degree of infection in these students.

Cause of the disease, diagnosis by x-ray and skin test, and treatment by rest, sunshine, diet, and surgical collapse of the infected lung are explained in the exhibit. Particularly important to California is the section devoted to the control of bovine tuberculosis.

The exhibit is under the direction of Mr. Ford Higby of the Association and Doctors Brown and Meyer of the committee.

Pneumonia.—Since pneumonia is the chief cause of death among infectious diseases, the most exciting medical discovery in the past decade has been the development of effective antiserums for the control of every type of pneumonia germ.

Complete coverage of all the thirty-two types was completed only during the winter of 1938, and the Golden Gate International Exposition was selected for the first public or medical display of these almost miraculous materials.

The pneumonia exhibit, under the sponsorship of the Lederle Laboratories, shows the causative agents of pneumonia, the results of infection, the new methods of diagnosing and "typing" the microbes, and the administration of the proper type of antiserum. A special section is devoted to production and protection of these serums. Emphasis is placed on the necessity of proper and early medical care and of efficient nursing.

The exhibit is under the direction of R. S. Childs, vice-president of the sponsoring company, and Doctor Meyer of the committee.

Diabetes.—The story of insulin and its use to relieve diabetes is told by the Eli Lilly & Company exhibit. Charts, diagrams, and animated models explain the meaning of diabetes, the cause and hereditary factors, and the treatment.

Special displays indicate chemical diagnostic tests for diabetes, the relation between sex and the disease, and the importance of diet and exercise in controlling it. Three points are emphasized—the facts that insulin is a normal body secretion, that its use in diabetes is merely to make up for a deficiency, and that insulin is not habit forming.

The exhibit is under the direction of Drs. Raymond Rice of the sponsoring company and Clare Shepardson, representing the Advisory Committee.

Sex Hormones.—Modern discoveries in the chemistry of sex are combined in one of the most up-to-date exhibits in the Exposition. Sponsored by the Schering Corporation, this exhibit shows the rôle of hormones in controlling normal sexual development and sex characteristics.

Featured is the transparent "hormone woman"—an animated display which illustrates the interrelationships of female sex hormones during normal life, pregnancy, and the menopause.

A second feature is a striking comparison of the tremendous benefits resulting from chemical syntheses of these hormones and their production on a large scale.

This exhibit is under the direction of Edward Diekerhoff of the company and Drs. Kelly, Frederick Fluhmann, and Herbert Evans.

The Sterols.—During the past decade, research workers have given more and more attention to the group of chemi-

(Continued on Page 46)

A Business HYPODERMIC

THE revival of business is largely dependent upon forward-looking business men with faith and vision. Lack of confidence, reflected by curtailment of advertising and printed matter, is easily sensed by the buying public. Business men no longer can lay the onus to the consumer—it is up to them to lead the way.

Having determined that printed matter is a much needed Business Hypodermic, the buyer should check up his printing connections. There are only three general considerations to weigh in this regard: GOOD PRINTING — PROMPT DELIVERY — FAIR PRICES!

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Although specializing in publication, book and catalog printing, we are daily producing some of the finest specimens of color printing in pamphlets, broadsides and folders.

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(Continued from Page 44)

cals known as the sterols. These complex substances, it has now been found, include dozens of chemicals which are extremely potent and often valuable to living tissue.

In a display sponsored by the Sandoz Chemical Works of Switzerland, these sterols are explained in simple forms. Included are such sterols as vitamin D, the sex hormones, snake poisons, toad poisons, morphin and other opium alkaloids, cancer-producing substances, and drugs which act on the heart. Major emphasis is placed on this last group and particularly on digitalis and its chemical relatives.

This exhibit is under the direction of Prof. Dr. Arthur Stoll in Basle, Switzerland, and Dr. H. Althouse in San Francisco, representing the company, and Doctors Leake and Silverman of the committee.

Sanitation.—The importance of sanitation in modern civilization is dramatically portrayed in an exhibit sponsored by the West Disinfecting Company. The display shows how the proper use of chemicals can protect homes, buildings, and entire cities from infectious diseases.

In one section of the exhibit there is shown a cross-section of a modern American city, with arrows indicating the danger spots where epidemics can start.

In other sections the exhibit explains individual antiseptics and disinfectants, and emphasizes how their use can save lives by preventing diseases which are costly in both health and money.

This exhibit is under the direction of John Marcuse of the sponsoring company and Doctor Silverman of the committee.

Accident Prevention. — Two integrated exhibits are placed in the medical section to stimulate prevention of accidents with their resultant injuries and deaths.

In one, the Motor Vehicle Department of the State of California shows the terrible toll taken annually by highway accidents. Its goal is the education of Californians to realize the dangers of driving, and to recognize and properly meet dangerous highway situations. This exhibit is under the direction of Ray Ingels and William Ragan.

In the second safety exhibit, the Aetna Casualty Company presents a number of testing devices, "reactometers," which enable visitors to test their own reaction capabilities.

This exhibit is under the direction of Stanley Withe.

Medical Statistics.—Medical statistics, the score card of man's fight against death, are included as part of a display sponsored by the Metropolitan Life Insurance Company. Animated exhibits show the changes noted during the past decades in birth rates, death rates, and mortality rates of the chief causes of death. A second section in this exhibit is devoted to the importance of proper nursing in the home. This exhibit is under the direction of Dr. William Shepard.

Industrial Safety.—Under the sponsorship of the California State Industrial Accident Commission, a particularly timely exhibit will be seen by visitors. In this display each visitor has the opportunity to learn something of the hazards of his own industrial group.

Attention is pointed to the particular hazards involved in agriculture, in lumber mills, in steel mills, in paint shops, in mines, in business offices. Moreover, the exhibit not only shows what hazards exist, but also indicates how they can be overcome.

This exhibit is under the direction of Timothy Reardon.

Social Welfare.—During the past ten years, social welfare has become more and more closely related to clinical medicine. In a display sponsored by the California State Department of Social Welfare, this relationship is explained to the public. The exhibit shows how the State of California is attempting to solve health questions which have a background of social problems.

A related exhibit shows how the State of California institutions treat the physically and mentally ill.

University of California.—Financed by a special $300,000 grant from the State of California, and with the coöperation of a dozen nationally famous universities, research institutes and museums, the University of California is sponsoring the largest exhibit in the Hall of Science, and one of the largest in the entire Exposition.

Part of this great display is devoted entirely to medicine, and, in addition, considerable space is given to subjects

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By pitting our instrument against your most difficult cases, we believe we can prove to you the truth of the statement that this "is the greatest advance in Hearing Aids for the past twenty years."

Consultation is private—and entails no charge or obligation. We will gladly prepare an Audiogram for any patient for whom you request such service—showing his hearing range *without* and also the increased range *with* the CRYSTALIC ACOUSTICON. Both graphs will be plotted on the same chart, so you can judge for yourself the improved and corrected hearing accomplished.

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which are closely related to the battle against disease. In the section on general biology, visitors will find exhibits explaining the structure and function of the body, and the embryology of man and other mammals. In the section on chemistry and physics, there are displays on one of the outstanding scientific discoveries of the twentieth century—the atom-bombarding cyclotron, developed by Dr. E. O. Lawrence of the University. The new device, it is pointed out, is expected to have important medical applications—in regard to its production of cancer-destroying neutron-rays and to its production of cheap radio-active chemicals as substitutes for radium.

The medical section itself is marked by two exhibits which show the medical importance to man of the vegetable and animal kingdoms. These exhibits illustrate the plants and animals which cause or carry disease, and the plant and animal products which can fight disease.

Following these comes a series of exhibits on the "March of Life"—the progress of a human being from conception to death. In this series are placed exhibits on the care of children and the prevention of children's diseases, on the prevention and treatment of diseases of middle age, on pregnancy and childbirth, and on diseases of old age.

Coöperating with University of California scientists in developing this exhibit are workers at Stanford University, University of California at Los Angeles, University of Rochester, the Rosenwald Museum, the Buffalo Museum, Harvard University, and the University of Cambridge.

This exhibit is under the direction of Mr. William Norton and Drs. Jay Pearson, K. F. Meyer, and Guy Millberry.

Exposition Hospital.—Expert medical care and modern hospitalization is available for the welfare of the millions of visitors to Treasure Island. A fully equipped four-room hospital has been established in the Administration Building, and has two six-bed wards and two complete treatment rooms. A completely modern surgery, provided with all the latest necessary equipment, will be staffed at all times by physicians, internes, and nurses.

Ambulances and first-aid stations at various points will assist during emergencies.

The hospital, although closed to the public, will be open for examination at all times to members of the medical profession. It is under the direction of Dr. Morton Gibbons of San Francisco.

Advisory Committee.—In order to assure maximum efficiency in the use of funds, exhibit space, and time, all details of the medical section of the Hall of Science are under the control of an Advisory Committee on Medicine.

This group, composed of the topnotch medical leaders in the San Francisco Bay area, assumed full responsibility for the general plans and details of every exhibit and every lecture.

Chairman of the advisory group is Dr. Chauncey D. Leake, professor of pharmacology of the University of California Medical School, a world-famous research worker in medical fields and leader in medical education. Serving with Doctor Leake are the following:

Drs. Loren Chandler and Langley Porter, deans of the Stanford and University of California Medical Schools, respectively; J. C. Geiger and Paul Barrett of the San Francisco Department of Health; Walter Dickie of the California State Health Department; Francis Carmelia of the United States Public Health Service; K. F. Meyer, head of the Hooper Foundation for Medical Research, University of California; Guy Millberry, dean of the University of California Dental School; Walter Brown of the Stanford University department of hygiene; C. M. Haring, head of veterinary science at the University of California; Wilfred Robinson of the American Dental Association and John Leggett of the California State Dental Association; Nina Simmonds, nutrition expert of the University of California; William Dock, pathologist of Stanford University; Charles Gilman Hyde, sanitary engineer of the University of California; C. L. A. Schmidt, professor of biochemistry at the University of California and dean of the University's School of Pharmacy; T. Henshaw Kelly of the California Medical Association; William

(Continued on Next Page)

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There are two units, The Colfax Hospital and the Bushnell Sanatorium, for the treatment of Pulmonary Tuberculosis.

The Colfax School for the Tuberculous is located in the pine clad Sierra Nevada foothills, at an elevation of 2400 feet; an elevation free from the fogs of the valleys and free from extremes of heat or cold.

This Institution supplies, among other advantages:—

1. Individual care and supervision under skilled physicians.
2. Education as to the essentials of recovery from, and the prevention of the spread of, disease.
3. Complete laboratory and x-ray equipment.
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(Continued from Preceding Page)

Shepard of Metropolitan Life; and Mr. Walter Gnerich, secretary of the Northern California Retail Druggists' Association.

Director of the Hall of Science and secretary of the Advisory Committee on Medicine is Dr. Milton Silverman, research associate of the University of California and science writer for many magazines and metropolitan newspapers.

Most People Unknowingly Have Ulcers.—Most people, without knowing it, are constantly having ulcers of the stomach which naturally repair themselves, H. E. Robertson, M. D., Rochester, Minnesota, points out in his article, "Ulcerative Gastritis and Residual Lesions," in *The Journal of the American Medical Association* for January 7.

These ulcers are the result of hemorrhages from the minute vessels of the mucous membranes of the stomach. Such hemorrhages are the most frequent physiologic changes of this organ. These hemorrhages take place because of food and drink intemperances, poisons, local infections, fevers, anemias, and emotional disturbances.

In most instances, the cycle involves hemorrrhage followed by death of the affected tissue, that is promptly digested by the juices of the stomach, leaving an ulcer which usually is repaired naturally.

However, when complete healing does not take place a lesion remains which develops into chronic ulcer. The causes of such failure of the stomach to repair the ulcer are as yet not fully determined by medical science.

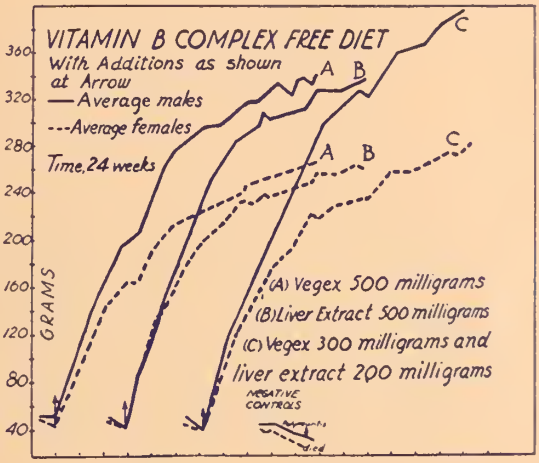
The author suggests that an insufficient amount of mucus at the hemorrhagic area may determine or retard healing of the ulcer. He also points out that the production of mucus may be under cerebral or emotional control.

Youth will never live to age unless they keep themselves in health with exercise, and in heart with joyfulness.—Sir P. Sidney.

VEGEX WITH LIVER EXTRACT

IN 1925, in a patent application, granted in 1930, the Laboratories of the Vitamin Food Company, Prince, recorded the discovery that the vitamins and endocrine extracts, particularly autolyzed yeast extract—Vegex—and liver substance—an extract—mutually supplement each other.

The chart shown here—Albino rat tests—confirms this. Vegex and a standard liver extract show well in the vitamin B complex, with special value when combined. In another series, with another liver extract, the results for eighteen weeks, are comparable to the chart shown here, and showing, further, that there is no appreciable difference between two parts Vegex and one part liver extract compared with one part Vegex and two parts liver extract.



In fifty-seven, independent, published reports from medical centers Vegex is shown high and regularly dependable in the extrinsic factor (anemias). Some of the workers, including Giglioli, Green-Armytage, Vaughan, Wills, Stewart and others, have observed favorable results when combining Vegex and liver extracts.

Green-Armytage (Ind. Med. Gaz., Penicious Anemia of Pregnancy, March, 1932), states:

> *"We have had excellent results with Vegex-Marmite given in 2 teaspoonful doses twice a day either in cold water or in soup. In a consecutive series of 50 cases I have no hesitation in stating that the clinical and pathological state of the patient greatly benefited as a result of Vegex-Marmite treatment."*

Vegex is a palatable, readily available and easily borne source of the vitamin B complex and the extrinsic factor, and economical for daily use by the patient. It gives a good flavor to liver diet. The value of the oral administration of Vegex, along with the intravenous use of the form of liver extract so used, or with the oral administration of liver extract seem worth while the physician's notice.

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SPECIAL PURPOSE FOOD for the VITAMIN B COMPLEX (including antineuritic B_1; riboflavin B_2; antipellagric G; complete vitamin B complex growth factor); the EXTRINSIC FACTOR and available FOOD IRON.

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INGREDIENTS

A brewers' yeast extract from a salt-enzyme autolyzing process—see analysis—with added pure vegetable flavor and added available iron salt—ferrous malate.

As used, a teaspoonful to a cup of liquid, the salt concentration is less than in toast. The vegetable flavor is of possibly no physiological significance. Meat like flavor, but entirely meat free. Starch and sugar free for restricted diets; easily borne by infants and patients on liquid diets.

VEGEX ANALYSIS

	Per Cent
Protein (N × 6.25)	32.6
Fat	0.8
Calories per ounce	40
Sodium Chloride	11.1
Phosphorus as P	2.62
Potassium as K	2.18
Calcium as Ca	0.098
Iron as Fe	0.048
Magnesium as Mg	0.13
Copper	0.00275
Manganese	Distinct Traces

B VITAMIN TEST

Average per Gram

Sherman-Chase B_1	45 units
International B_1	25 units
Sherman-Bourquin riboflavin	35 plus units
B Complex full growth	2 to 3 units

Mass clinical use indicates one man unit each anti-beriberi, anti-pellagric and extrinsic factor (anemias) per ounce.

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Adequate nutrition requires the whole of the vitamin B complex. Vegex supplies it.

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Recommended in public health work where cost is a deciding factor, or in rural districts where repeated injections are impractical. Full 1 c.c. Cutter dose prevents the reactions due to the greater concentration of alum in the ½ c.c. dose.

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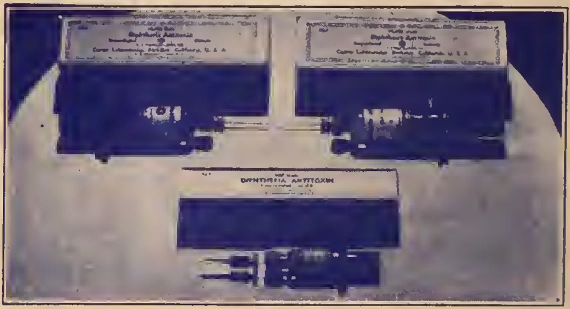

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CALIFORNIA AND WESTERN MEDICINE

Official Journal of the California Medical Association

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OF MEDICINE
MAR 22 '39
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VOLUME 50
NUMBER 3

MARCH · 1939

50 CENTS A COPY
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Owned and Published Monthly by the California Medical Association

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"Entered as second-class matter at the post office at San Francisco, under the Act of March 3, 1879." Acceptance for mailing at special rate of postage provided for in Section 1103, Act of October 3, 1917, authorized August 10, 1918.

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Communications for the Public Relations Department should be addressed to the Director, George H. Kress, M. D., Room 2004, 450 Sutter Street, San Francisco.

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Secretary, Gertrude Moore, 2404 Broadway, Oakland.

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Butte County Medical Society

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Secretary, J. O. Chiapella, 131 Broadway, Chico.

Meeting, *Second Thursday.*

Contra Costa County Medical Society

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Secretary, Clifford E. Dieterich, 1306 Pomona Avenue, Crockett.

Meeting, *Second Tuesday, 8 p. m.*

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Meeting, *First Tuesday, University-Sequoia Club, Fresno.*

Humboldt County Medical Society

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Secretary, Joseph S. Woolford, 350 E Street, Eureka.

Meeting, *First Thursday.*

Imperial County Medical Society

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Secretary, William A. Clarke, Holtville.

Meeting, *Third Tuesday, 7 p. m., Barbara Worth Hotel, El Centro.*

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Secretary, C. S. Compton, 428 C Street, Bakersfield.

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Kings County Medical Society

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1925 Wilshire Boulevard, Los Angeles

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Secretary, George D. Maner, 1925 Wilshire Boulevard, Los Angeles.

Meetings, *First and Third Thursdays, 1925 Wilshire Boulevard, Los Angeles.*

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Meeting, *On Call.*

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Meeting, *Third Thursday, Hotel Tioga, Merced.*

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Secretary, Herbert Archibald, Salinas National Bank Building, Salinas.

Meeting, *First Thursday.*

Napa County Medical Society

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Secretary, M. M. Booth, Bruck Building, St. Helena.

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Meeting, *At Call of President.*

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President, N. K. Bear, 3655 Fourteenth Street, Riverside.

Secretary, Thomas A. Card, 3616 Main Street, Riverside.

Meeting, *Second Monday, 8 p. m., Library, Riverside Community Hospital.*

Sacramento Society for Medical Improvement

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Secretary, Glenn E. Millar, 321 Physicians Building, Sacramento.

Meeting, *Third Tuesday, 8:30 p. m., Auditorium, Sacramento.*

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Secretary, L. E. Smith, Hollister.

Meeting, *At Call of President.*

San Bernardino County Medical Society

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Secretary, A. E. Varden, Medico-Dental Building, San Bernardino.

Meeting, *First Tuesday, 8 p. m., San Bernardino County Charity Hospital.*

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Fourteenth Floor, Medico-Dental Building,
233 A Street, San Diego

President, Hall G. Holder, 1109 Medico-Dental Building, San Diego.

Secretary, C. V. Bernardini, Medico-Dental Building, 233 A Street, San Diego.

Meeting, *Second Tuesday, El Cortez Hotel.*

San Francisco County Medical Society

2180 Washington Street, San Francisco

President, Edwin L. Bruck, 384 Post Street, San Francisco.

Secretary, Stanley H. Mentzer, 2180 Washington Street, San Francisco.

Meetings, *Every Tuesday, 8:15 p. m., 2180 Washington Street, San Francisco.*

San Joaquin County Medical Society

President, N. P. Johnson, Medico-Dental Building, Stockton.

Secretary, George H. Rohrbacher, Medico-Dental Building, Stockton.

Meeting, *First Thursday, 8:15 p. m., Medico-Dental Club Rooms, Stockton.*

San Luis Obispo County Medical Society

President, J. B. V. Butler, 722 Marsh Street, San Luis Obispo.

Secretary, E. M. Bingham, County Health Department, San Luis Obispo.

Meeting, *Third Saturday, 6:30 p. m., Gold Dragon Cafe, San Luis Obispo.*

San Mateo County Medical Society

President, N. D. Morrison, 205 Third Avenue, San Mateo.

Secretary, J. Garwood Bridgman, 205 Third Avenue, San Mateo.

Meeting, *Fourth Wednesday, Benjamin Franklin Hotel, San Mateo.*

Santa Barbara County Medical Society

President, W. H. Johnston, 1515 State Street, Santa Barbara.

Secretary, D. H. McNamara, 317 W. Pueblo Street, Santa Barbara.

Meeting, *Second Monday, Cottage Hospital.*

Santa Clara County Medical Society

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Secretary, Leslie B. Magoon, 652 East Santa Clara Street, San Jose.

Meeting, *Third Wednesday, 8 p. m., Medico-Dental Building, San Jose.*

Santa Cruz County Medical Society

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Meeting, *First Monday, 7:30 p. m., Club Rio del Mar, Aptos.*

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Meeting, *Second Monday.*

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Secretary, Victor W. Hart, 113 No. Oregon Street, Yreka.

Meeting, *Sunday on call.*

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Meeting, *Second Tuesday, 8 p. m., Casa de Vallejo Hotel, Vallejo.*

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Meeting, *Second Thursday.*

Stanislaus County Medical Society

President, John A. Cooper, 1024 J Street, Modesto.

Secretary, Hoyt R. Gant, 403 Beaty Building, Modesto.

Meeting, *Second Friday, 7:30 p. m., Hotel Hughson.*

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Secretary, R. G. Frey, Red Bluff.

Meeting, *At Call of President.*

Tulare County Medical Society

President, Newton Miller, 231 No. Main Street, Porterville.

Secretary, Ray Cronemiller, Exeter.

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Ventura County Medical Society

President, W. F. Mosher, 34 No. Ash Street, Ventura.

Secretary, A. A. Morrison, 625 Main Street, Santa Paula.

Meeting, *Second Tuesday, Ventura County Country Club.*

Yolo-Colusa-Glenn County Medical Society

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Secretary, W. J. Blevins, Jr., Woodland.

Meeting, *First Tuesday.*

Yuba-Sutter County Medical Society

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"There is definitely a relation," said Doctor Rosenthal, "between diet and toxicity of the drug and its derivatives which scientists must consider in their future studies, although its explanation is yet unknown."

Previously noted had been the occurrence of peripheral neuritis in human beings following the use of the derivative "di-sulfanilamid," emaciation and motor weakness in pigeons following oral administration of the methyl derivatives of this compound. Mice and rats were found to possess a low toxicity; guinea pigs to show cumulative effects.

The present study was made to investigate the problem of these cumulative and delayed effects following repeated doses of both the parent drug and its compound. Two sets of experiments were carried out: one, with rabbits, to determine the effects of diet on toxicity; another, with hens, ultimately, "to produce an animal counterpart of the specificity of action" similar to polyneuritis in man. All drugs used in the tests were given orally in varying doses; diet for rabbits consisted of either oats or cabbage alone or both, and for hens, a standard commercial chicken feed.

The results showed that sulfanilamid possesses a cumulative toxicity in rabbits. Repeated administration led to nervous symptoms, weakness, emaciation, and a considerable mortality.

The influence of diet was shown in that a dosage of the drug, which was tolerated by rabbits on a cabbage diet, caused a high percentage of deaths in those animals on a diet of oats plus cabbage, or oats alone.

Daily administration of sulfanilamid to hens produced neuromuscular weakness and emaciation. Death frequently occurred and was often delayed for one to four weeks subsequent to treatment. The appearance of many of these hens, according to Doctor Rosenthal, "suggested peripheral neuritis, but in many animals it was not possible to establish this condition on a pathological basis."

Repeated daily doses of the compound, di-sulfanilamid, also produced cumulative and delayed toxic effects, both to rabbits and chickens. The drug was somewhat less toxic than sulfanilamid, the studies reveal; and results in rabbits also differed in that no differences in mortality were observed in the animals on oat and cabbage diets.

The results of these studies, according to the author, but again emphasize the need for the use of several species of animals kept under controlled conditions in similar research.

"Most important point yet to be determined," concluded Doctor Rosenthal, "is the extent to which cumulative toxicity of the drug occurs in man, particularly under those conditions often present during therapy—restriction of diet and toxemia. In man, the usual toxicity symptoms differ again from those seen in animals: therefore, the delayed toxic effects from sulfanilamid as seen in chickens must be given no clinical implications. This, because of the relatively large doses administered in these experiments, and because similar effects so rarely occur in man following its use."

There is still an immense amount to be learned about health, but if what is at present known to a few were part of the general knowledge, the average expectation of life could probably be increased by about ten years.—J. B. S. Haldane.

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Golden Gate International Exposition, Treasure Island in San Francisco Bay.—Treasure Island, new man-made World's Fair and airport island in San Francisco Bay, moved actively into both phases of its career during the California "winter" just past.

On February 18 the $50,000,000 Golden Gate International Exposition swung wide its Portals of the Pacific for 20,000,000 anticipated visitors before it closes on December 2, 1939.

Just a few weeks earlier, Pan-American Airways moved its transpacific base to Treasure Island; received the China Clipper there after a scheduled flight from Hongkong, and took delivery of the first of the huge 74-passenger Boeing Clippers—largest flying boats in the world—which will operate regularly from Treasure Island during the Western World's Fair.

The China Clippers, landing and taking off in sight of Exposition visitors and receiving terminal overhaul behind glass walls, are one of the foremost "exhibits" on Treasure Island. Other exhibitors include more than three hundred outstanding American industries, representing every field of activity and interest.

Thirty foreign nations, most of them in pavilions of distinctive racial architecture, lend atmosphere to the four hundred acres of the Western World's Fair. Fourteen states, a cross-section of carnival gaiety in the forty-acre Gayway, a history-making collection of Old Masters, contemporary and decorative arts, and outstanding demonstrations of scientific marvels are other features of the compact Pageant of the Pacific.

Its buildings are of two sorts: a mystic, lovely "Pacific" architecture for the romanticists, blending ancient Mayan, Incan, and Cambodian forms into new beauty; and another section of streamlined modernistic structures, separated from the others by lagoons, for tastes which reach boldly forward.

Both groups are framed within a lavish California garden setting which cost $1,500,000, and glorified at night by illumination which makes wide use, at a cost exceeding $1,000,000, of the new "fluorescent tube" for unimagined beauty in colored floodlighting. Sculptures, murals, abound.

Scorning mere size, the West's World's Fair—squarely between the world's two greatest bridges—has gone in for beauty, for fun, for relaxation from the cares of every day. It is the focal point for a year of merrymaking between the Continental Divide and the Pacific Ocean, and the world is invited to "Be the Guest of the West in '39."

Like a great white wedding cake, Treasure Island rises from blue San Francisco Bay and looks westward through the Golden Gate—a Shangri-La, a Never-Never Land where any dream may come true, and pleasure beckons.

The load of tomorrow added to that of yesterday, carried today, makes the strongest falter. Shut off the future as tightly as the past. No dreams, no visions, no delicious fantasies, no castles in the air, with which, as the old song so truly says, "hearts are broken, heads are turned." To youth, we are told, belongs the future, but the wretched tomorrow that so plagues some of us has no certainty, except through today. Who can tell what a day may bring forth? Though its uncertainty is a proverb, a man may carry its secret in the hollow of his hand. Make a pilgrimage to Hades with Ulysses, draw the magic circle, perform the rites, and then ask Tiresias the question. I have had the answer from his own lips. The future is today—there is no tomorrow! The day of a man's salvation is now—the life of the present, of today, lived earnestly, intently, without a forward-looking thought, is the only insurance for the future.—William Osler, M. D., 1913.

Let him who knows little, play safe, whatever his job, and even though he be not adjudged smart, he will be adjudged sound. He who knows much may take a chance, and let his imagination roam; but he who knows little, and takes chances, voluntarily tries suicide; keep always to the right, for what is established as right cannot be wrong; the king's highway is fixed for the simpleton, and this law for everybody, know he much, or know he little, that there is better sense in safety than in singularity.—Baltazar Gracian, 1653.

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UNIVERSITY of CALIFORNIA MEDICAL SCHOOL
SAN FRANCISCO, CALIFORNIA

National Institute of Health. — The United States Treasury Department announces that construction will be started immediately on two additional laboratory buildings and living quarters for fourteen of the medical officers and their families at the National Institute of Health near Bethesda, Maryland.

With the completion of these two new laboratory buildings and the National Cancer Institute Building, which was started last November, Doctor Thompson said that facilities will be available at the Bethesda center for about six hundred scientific investigators, laboratory technicians, and research workers. The Institute is concerned with many public health problems, ranging all the way from the control of serums and vaccines to determining the number of hours which bus and truck drivers can work without suffering undue fatigue which endangers life on the highways.

One of the new laboratory buildings will house the Divisions of Infectious Diseases, and Biologics Control. The other will be used by the Divisions of Chemistry, Pharmacology, and Zoölogy. The buildings are being erected on the original plot of forty-five acres of land fronting on the Rockville Pike near Bethesda, which was given to the National Institute of Health in 1935 by the late Luke I. Wilson and Mrs. Wilson. Subsequent deeds by Mrs. Wilson in 1937 and 1938 have increased the grounds to about sixty acres. Her latest gift includes the land which will be used for the officers' quarters and the National Cancer Institute building. It is expected that the Cancer Institute will be completed early in July of this year, and the laboratories at Cambridge, Massachusetts, and in the Institute buildings at Twenty-fifth and E streets will be moved into the new building at that time.

The two new laboratory buildings, which are also scheduled for completion by the spring of 1940, will be 50 feet wide and 250 feet long, and each will contain three floors, two basements, and an attic. All the space in the buildings will be devoted to laboratories and scientific equipment.

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The officers' quarters will consist of two detached houses and six semi-detached dwellings. The entrance will be from Cedar Lane, and the buildings will be arranged in semi-circular fashion with an attractive flagstone walk between them. It is expected that these dwellings will be ready for occupancy by April 1, 1940.

The living quarters at the Institute will be occupied by the director and assistant director and by other medical officers who may be stationed at the Institute from time to time. The officers are required to pay rent. Construction costs for these buildings will be amortized over a sixteen-year period.

Look to your health; and if you have it, praise God and value it next to a good conscience; for health is the second blessing that we mortals are capable of—a blessing that money cannot buy; therefore value it, and be thankful for it.—Izaak Walton.

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Half of Low Salary City Diets Below Standard, Survey Shows.—From the standpoint of nutrition, 40 to 60 per cent of family diets of white employed city workers appear to be in need of improvement and the same is true for about 60 per cent of the diets for negro families.

This finding is from an analysis by Dr. Hazel K. Stiebeling and Esther F. Phipard of the Federal Bureau of Home Economics from a study of more than 4,000 dietary records obtained in 1934-1937 from families of employed wage-earners and low-salaried clerical workers in cities in eight major geographical regions. Complete details of the study are available in Circular 507, just published by the United States Department of Agriculture.

At every expenditure level above a certain minimum, Doctor Stiebeling points out, some families succeeded in obtaining good diets, but others provided themselves with a diet only fair or poor from a standpoint of nutritive value. For example, with an average food expenditure of $2.50 a person a week, which is higher than the median in all areas, 32 per cent of the families in the East South Central area bought good diets, while another 37 per cent obtained diets that were classed as poor.

The cost of buying diets with a wide enough margin of safety in protein, minerals, and vitamins to be rated good varied somewhat from one region to another. This study found the minimum expenditure for diets with this wide margin of safety to range from about $1.90 a person a week for negro families in the South to about $2.75 a person a week for white families in North Atlantic cities.

Based on recent studies made in the Bureau, the study reveals that about one-third of the white families obtained diets high enough in vitamin A to insure good visual adaptation in semidarkness. The diets of only one-fifth of the families insured a liberal allowance of vitamin A.

The pellagra-preventive factor appears amply supplied except in the Southeast, where the deficiency in low-income groups is serious. Here it was found that not enough was spent for fresh vegetables, milk, and cheese.

For a good diet it has been suggested that as much of the food budget be spent for milk and cheese, and also for fruits and vegetables, as for eggs, lean meat, poultry and fish. The study showed that white families spent from one-fourth to one-third of their food money for eggs, lean meat, poultry and fish; from one-fifth to one-fourth for vegetables and fruits, and only one-eighth to one-sixth for milk and cheese. Negro families spent almost one-third for eggs, lean meat, poultry, and fish; about one-sixth for vegetables and fruits, and only 6 per cent for milk.

Usual diets of these families included fewer eggs, less than two-thirds as many vegetables and fruits, and from one-half to one-third as much milk as diets graded as good. Doctor Stiebeling suggests that many present-day diets may be improved considerably in nutritive value not by spending more, but by spending more wisely.

The family records were gathered by the Cost of Living Division of the Bureau of Labor Statistics and the analysis of content, cost, and nutritive adequacy of diets was made by the Bureau of Home Economics in coöperation with the Works Progress Administration. Only nonrelief families with incomes of at least $500, but not more than $2,000 or more than $200 for any one month, during the preceding year were included in the study. The group possibly represents a higher economic level than characterizes city wage-earners as a whole, in the opinion of Doctor Stiebeling.

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Total Number of Blind Persons in the United States. There are at least 117,000 totally blind persons in the United States, according to estimates of the National Health Survey which were recently made public by the United States Public Health Service.

In presenting this figure, George St. John Perrott, director of the survey, stated that blindness, which already constitutes a major problem in society, will be likely to increase because older persons, among whom blindness is more prevalent, are constituting a larger and larger proportion of the population. One-fourth of the blind are over seventy-five years of age and three-fifths are over fifty-five.

Cataract, glaucoma, trachoma, optic-nerve atrophy and other eye diseases coupled with more general diseases such as high blood pressure, hardening of the arteries and diabetes, are responsible for nearly three-fourths of all blindness. The rest is attributed to accidents (about 21 per cent) and congenital or early infancy causes (approximately 7 per cent).

Among the accidents causing blindness—which account for about one-fifth of the entire amount—the largest single cause is falls (16 per cent); next in order come automobile accidents and burns (each 10 per cent); and poisonings and firearms (each 7 per cent); the remaining 50 per cent is distributed over a large number of known and unknown types of accidents. Forty-three per cent of these accidents are classified as occupational injuries, those occurring at work; 27 per cent occurred in the home and 30 per cent in public places, including automobile accidents.

The report pointed out that blind persons are concentrated in the low-income groups. Seventy per cent were found to be in families with annual incomes of less than $1,000.

The prevalence of blindness among men is greater than among women, according to Survey findings. For every 100 blind women there are 111 men afflicted with blindness. Among youths (15 to 24 years), the prevalence rate for males is 20 per 100,000, while the female rate is only 9 per 100,000. Figures for the younger working ages (25 to 44) show a prevalence of 144 blind per 100,000 men, while the rate for women is only 28. In the oldest age grouping (65 and over), however, the rate is 706 per 100,000 women to 660 per 100,000 men.

The Survey found nearly twice as much blindness among colored people as among whites in proportion to their numbers. The rate of blindness for colored persons is 146 per 100,000 as contrasted with 75 for the white population.

Only 11 per cent of the blind were reported as being employed in gainful occupations, leaving the greater number dependent upon private or public support.

This study of the National Health Survey was primarily concerned with total blindness, which included "all persons reported by the family as being blind in both eyes." In connection with the study, however, figures for blindness in only one eye were compiled and it was estimated that "in the general population there were about 425,000 persons blind in one eye only," as against 117,000 persons blind in both eyes.

The National Health Survey was a project conducted by the United States Public Health Service with the aid of financial grants from the Works Progress Administration. The results are based on a house-to-house canvass of some 800,000 families, including 2,800,000 persons in eighty-three cities and twenty-three rural areas in nineteen states. The Survey was made during the winter (largely from November to March) of 1935-1936.

The total surveyed population was so distributed as to give a sample which was, in general, representative of cities in the United States according to size and region. In large cities (100,000 and over) the population to be canvassed was determined by a random selection of many small districts based on those used in the United States Decennial Census of 1930. In the smaller cities selected for the study, the population was enumerated completely.

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BOOKS RECEIVED

Pocket Pronouncing Medical Dictionary. By the Late George M. Gould, A. M., M. D. Eleventh edition of over 40,000 words. Revised by C. V. Brownlow. With Tables, Physicians' and Veterinarians' Dose-Lists, Appendix of Useful Data. Flexible, Washable Fabric. Pp. over 1000. Price, $2; with thumb index, $2.50. Philadelphia: P. Blakiston's Son & Co., Inc., 1939.

Alcohol in Moderation and Excess. A Study of the Effects of the Use of Alcohol on the Human System. By J. A. Waddell, M.D., Professor of Pharmacology, Materia Medica, and Toxicology, Medical Department, University of Virginia, and H. B. Haag, M. D., Professor of Pharmacology, Medical College of Virginia. In Collaboration with Committees from the Faculties of the State-Supported Medical Schools of Virginia. Cloth. Pp. 184. Price, $1. Richmond, Virginia: The William Byrd Press, Inc., 1938.

A Manual of Fractures and Dislocations. By Barbara Bartlett Stimson, A. B., M. D., Med. Sc.D., F. A. C. S., Associate in Surgery in the College of Physicians and Surgeons, Columbia University, New York City; Assistant Attending Surgeon to the Presbyterian Hospital, New York City. Limp binding. Pp. 214, illustrated with 95 engravings. Price, $2.75. Philadelphia: Lea & Febiger, 1939.

Fundamentals of Experimental Pharmacology. By Torald H. Sollmann, M. D., Sc.D., Professor of Pharmacology and Materia Medica, and Dean of the School of Medicine, Western Reserve University, Cleveland, Ohio; Chairman, Council on Pharmacology and Chemistry, American Medical Association, and Paul J. Hanzlik, A. M., M. D., Professor of Pharmacology, Stanford University School of Medicine, San Francisco; Vice-Chairman, Council on Dental Therapeutics, American Dental Association. Second Edition. Cloth. Pp. 307, illustrated. Price, $4.25. San Francisco: J. W. Stacey, Inc., 1939.

A Fundamental Approach to Bacteriology. By Courtland Sawin Mudge, Ph.D., Dairy Bacteriologist in the Experiment Station and Associate Professor of Dairy Industry, University of California, and Floyd Russell Smith, Ph. D., Junior Dairy Bacteriologist in the Experiment Station and Instructor in Dairy Industry, University of California. Paper. Pp. 265. Price, $3. San Francisco: J. W. Stacey, Inc., 1939.

Surgical Pathology of the Diseases of the Mouth and Jaws. By Arthur E. Hertzler, M. D., Surgeon to the Agnes Hertzler Memorial Hospital, Halstead, Kansas, Professor of Surgery, University of Kansas. Cloth. Pp. 248, with 206 illustrations. Price, $5. Philadelphia: J. B. Lippincott Company, 1938.

Trauma and Internal Disease. A Basis for Medical and Legal Evaluation of the Etiology, Pathology, Clinical Processes, Following Injury. By Frank W. Spicer, A. B., M. D., F. A. C. P. Cloth. Pp. 593, with 43 illustrations. Price, $7. Philadelphia: J. B. Lippincott Company, 1939.

Immunity Principles and Application in Medicine and Public Health. By Hans Zinsser, M. D., Professor of Bacteriology and Immunology, Harvard Medical School; John F. Enders, Ph. D., Assistant Professor of Bacteriology and Immunology, Harvard Medical School; and LeRoy D. Fothergill, M. D., Assistant Professor of Bacteriology and Immunology and Associate in Pediatrics, Harvard Medical School. Fifth Edition of "Resistance to Infectious Diseases." Cloth. Pp. 801. Price, $6.50. New York: The Macmillan Company, 1939.

(Continued on Page 15)

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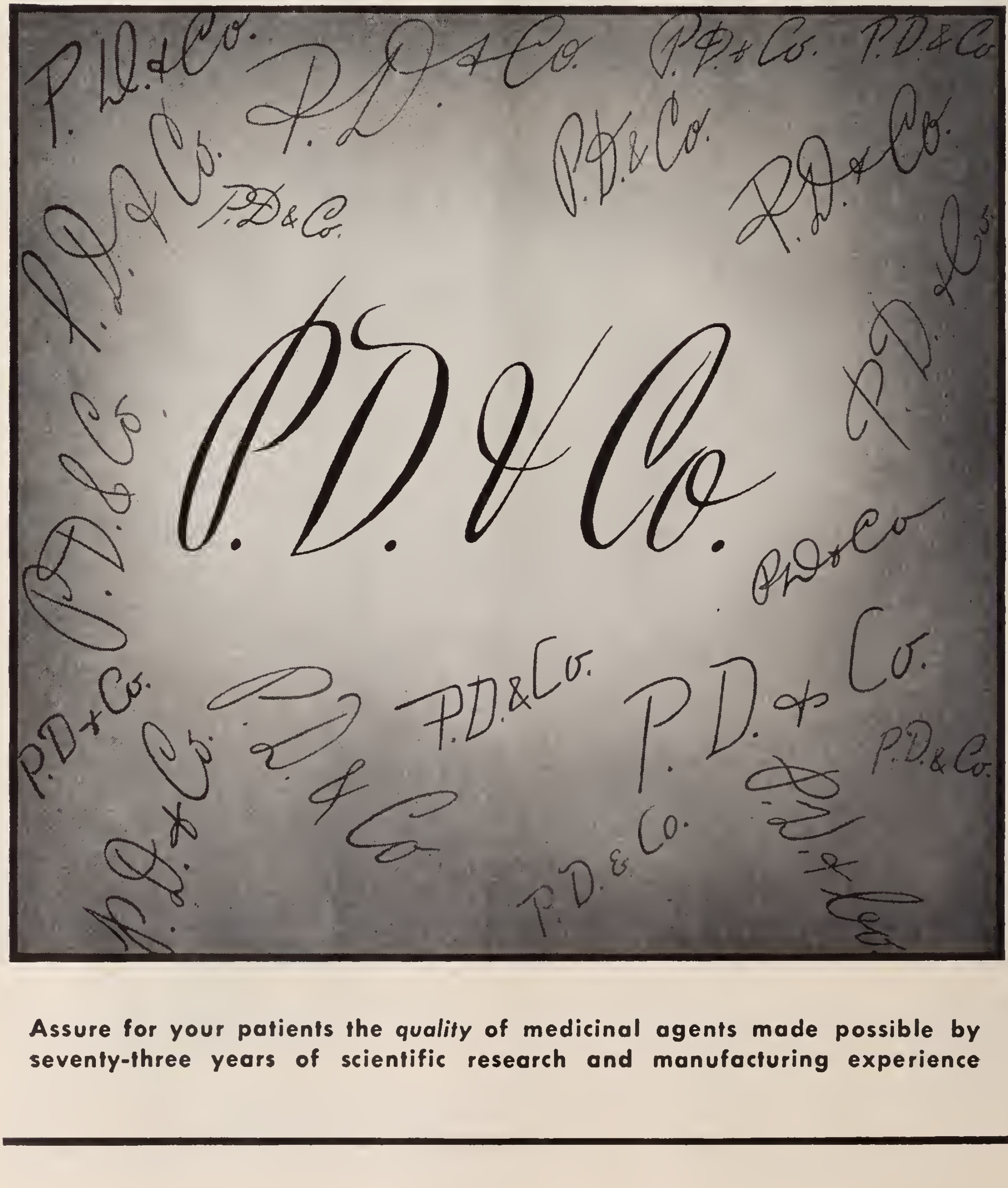
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BOOKS RECEIVED

(Continued from Page 13)

Sixty-Fourth Annual Report of the Commissioner of the Michigan Department of Health, for the Fiscal Year Ending June 30, 1936. Cloth. Pp. 669. Lansing: Franklin DeKleine Company, 1938.

Life's Beginning on the Earth. By R. Beutner, M. D., Ph. D., Professor of Pharmacology at the Hahnemann Medical College and Hospital of Philadelphia. Cloth. Price, $3. Pp. 222, with 80 illustrations. Baltimore: The Williams & Wilkins Company, 1938.

Jefferson, the Forgotten Man. By Samuel B. Pettengill, Member of Congress. With a foreword by Douglas Johnson, Author of "The Assault on the Supreme Court." Cloth. Pp. 249. Price, $1.50, in cloth; $1 in paper. New York: America's Future, Inc., 1938.

Annual Report of the Surgeon-General of the Public Health Service of the United States. For the Fiscal Year, 1938. Cloth. Pp. 184. Price, 60 cents. Washington: United States Government Printing Office, 1938.

How to Avoid Financial Tangles. By Kenneth C. Masteller. Paper. Pp. 160. Price, $1. Cambridge, Massachusetts: American Institute for Economic Research, 1939.

Migration for Settlement. In Technical and Financial International Coöperation with Regard to Migration for Settlement. Paper. Pp. 180. Price, $1. Washington: The International Labor Office, 1938.

Annual Report of the Public Health Commissioner with the Government of India for 1936. Volume I, with Appendices. Paper. Pp. 353. Price, three shillings and sixpence. New Delhi: Government of India Press, 1938.

BOOK REVIEWS

Modern Surgical Technic. By Max Thorek, M.D., K.L.H., K. C., Professor, Clinical Surgery, Cook County Graduate School of Medicine, Chicago. With a foreword by Donald C. Balfour, M. B., M. D., LL. D., Head of Section in Division of Surgery, The Mayo Clinic, Rochester, Minnesota. Complete in three volumes. Volume I: General Operative Considerations; Surgery of the Head and Neck, and Plastic Surgery. Volume II: Surgery of Nerves, Vessels, Bones; Surgery of Breast and Chest. Volume III: Abdominal Surgery, Hernia, Genito-Urinary and Gynecologic Surgery. Cloth. Price, $33 per set. Pp. 526; 527-1229; 1231-2045, with 2,174 illustrations, originals principally by W. C. Shepard. Philadelphia, New York, Montreal, and London: J. B. Lippincott Company, 1938.

This work consists of three volumes of well-illustrated surgical technique, so written as to be concise, but still explain the different procedures in a way that can be understood by a surgeon who is trained in general surgical principles but not especially experienced in the particular operation in question. The general plan of the work is to give a brief discussion of the problem and then a step by step description of the operation. Whenever possible, more than one method of performing each operation is given. Two thousand one hundred seventy-four illustrations and diagrams help the reader picture the steps as they are described. This work is not merely a description of the author's technique, but a description of operations devised by others which the author feels are most valuable to the reader.

Volume I presents the general operative considerations and covers the surgery of the head and neck and plastic surgery. Preoperative preparation and the commoner postoperative sequelae, both immediate and late, are adequately discussed. The arrangement and equipment in an operating room, together with operating-room technique receives special attention. This includes a discussion of the various methods of sterilization. The author devotes nearly fifty pages to anesthesia. This section is well illustrated, and presents apparatus, methods and technique, indications and contraindications for general, regional and local anesthesia, describing in detail, spinal anesthesia,

(Continued on Next Page)

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BOOK REVIEWS

(Continued from Preceding Page)

sacral and parasacral, paravertebral and splanchnic anesthesia. The author conforms to the method of presenting this technique used throughout his three volumes. Each step is given precisely and in detail and in proper sequence.

Operations on the head and neck are grouped according to structural regions and cover the ordinary operative procedures of the eye, ear, nose, and throat, as well as the surgical problems of the scalp, skull, brain, mouth, and neck. In many instances, two or more operative procedures for the same condition are described and illustrated in detail. Operations for injuries and diseases of the mandible are particularly well presented. An excellent chapter on the principles of plastic surgery and skin grafting, illustrated by drawings, diagrams and photographs, concludes Volume I.

Volume II is given over to descriptions of the surgery of nerves, vessels and bones, and in its second part to surgery of the breast and chest. In the section on surgery of the nerves, a discussion is given of the general principles involved in neurolysis, capsulectomy and methods of nerve sutures with many diagrams. Following this discussion, specific operations are given in detail. A rather large section is devoted to surgery of the sympathetic system, giving well-illustrated descriptions of most of the important operations.

One hundred pages are devoted to surgery of the vascular system. The technique of arteriorrhaphy is discussed in detail, giving various methods of suture. A large part of the text is devoted to ligation of vessels at specific points. Here the landmarks for localizing the incisions are given, and how and where to tie the vessels is told. Some twenty pages are given to discussion and operative technique in aneurysm in general and in specific localities. Treatment of varices is briefly but sufficiently discussed, as is transfusion and surgery of the lymphatic system.

Orthopedic surgery is described in about three hundred and fifty pages, the first third describing various open operations, the remainder amputation, fracture, and dislocation. Surgery of the breast is well described, naturally devoting most of the space to radical mastectomy, although a fair amount of space is given to plastic operations. The radical operation is fully described. Several incisions are given, the rest of the operation given by steps. The author favors the use of the radio knife and presents a series of excellent illustrations.

The final one hundred and fifty pages are devoted to thoracic surgery, including the so-called basic operations on the thorax, such as rib resection, wounds of the lung, thoracoplasty, operation for empyema, etc. Lobectomy is described in considerable detail. Two techniques are given for pulmonary embolectomy and a few pages are given to surgery of the mediastinum and the heart, including suture of heart wounds and Beck's operation to increase the blood supply to the heart muscle.

Volume III discusses surgery of the abdomen and pelvis. An adequate amount of space is devoted to the opening and closing of the abdomen, giving the various incisions and techniques for closing. Surgery of the stomach, amply illustrated, is described in the next one hundred pages, giving several methods for most of the lesions described. The author then takes up surgery of the intestines, in which he gives various methods of enterostomy, colostomy and resections, including those of the large and small bowel, appendix, etc. Next the author describes a series of rectal operations. A chapter is devoted to operations on the liver and biliary passages, and another one each to surgery of the pancreas and the spleen.

A fairly long chapter is devoted to the repair of various types of hernia. A very clearly described and illustrated discussion is given of several different operations for the common hernias, and an excellent discussion on diaphragmatic hernia. One hundred and twenty pages are given to gynecological surgery, in which most of the necessary operations are clearly described. In the final two hundred pages the author describes the operations on the genito-urinary organs, such as operations on the kidney, transplantation of ureters, operations on the bladder and plastic operations on the genitals. L. R. C. and E. L. R.

Manual of Psychiatry. By Aaron J. Rosanoff, M. D. Seventh edition. New York: John Wiley & Sons, Inc.; London: Chapman & Hall, Ltd., 1938.

Rosanoff's "Manual of Psychiatry and Mental Hygiene" should be read by psychiatrists and students of psychiatry, if for no other reason, because it differs so greatly from

(Continued on Page 18)

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BOOK REVIEWS

(Continued from Page 16)

the usual textbook on psychiatry. That the readers may not agree with the author in a number of particulars, may be expected. The fact that he does not conform completely to the usual, in itself constitutes good reason for reading his book. From the French "Manuel de Psychiatrie" by J. Rogues de Fursac, published in 1902 and translated by Rosanoff in 1905, to the present edition of the Manual, there has transpired not only a period of thirty-three years but also an almost complete metamorphosis of the content. Eventually, the author has extensively set forth his own views of psychiatry and related subjects, with due mention of various views of others, in a book of 1,091 pages.

In Part I, General Psychiatry, are separate chapters on Etiology; Symptomatology; Neuropsychiatric Syndromes; and General Pathology of Mental Disorders.

In Part II, Special Psychiatry, are chapters on Classification; Huntington's Chorea; Amaurotic Family Idiocy; Hereditary Mental Deficiency; Mongolism; Cerebral Birth Trauma; Postnatal Birth Trauma; the Meningitides and Encephalitides; Neurosyphilis; Alcoholism; Drug Addictions; Other Exogenous Toxins; Autotoxic Psychoses; Endocrine Disorders; Nutritional Deficiencies; Intracranial Tumors; Cerebral Arteriosclerosis; Senile and Presenile Deteriorations.

Thus far one finds familiar presentations of the subjects, at times meager, but with lengthy case histories and much statistical detail. But now the reader arrives at a chapter, entitled "Chaotic Sexuality, Including So-Called Schizophrenic Psychoses," and finds a "breaking up of what was once thought to be a pathologic entity," with case histories dealing particularly with homosexuality. This is followed by a chapter on Affective-Reaction Groups, Including So-Called Manic-Depressive Psychoses. The remaining chapters concern Antisocial Personalities; Mixed, Transitional, Borderline and Miscellaneous Groups; and A Theory of Temperament, Based Mainly on Psychiatric Experience.

Part III, The Practice of Psychiatry, includes Methods of Investigation; Therapeutic Techniques; Psychoanalysis; Medico-Legal Questions; Military and Industrial Psychiatry. In his chapter on Psychoanalysis, the author quotes extensively from Freud's writings. The subject matter is, accordingly, fairly stated, but the reader may find it bewildering, particularly if he lacks previous comprehensive knowledge of this special method of psychotherapy.

In Part IV, one finds very interesting interpretations of mental hygiene. In Part V are set forth in detail various special diagnostic procedures. In Part VI appear the official classification of mental disorders; tables of height and weight; tables of intelligence quotients; and, finally, a glossary of index of subjects and authors.

The author wishes to provide the student with a "working manual." He does not attempt completeness of all presentations, yet provides a considerable amount of statistical analysis. He does not regard the Manual to be a source book, yet each chapter is terminated with an extensive bibliography. The book should stimulate individual thinking and investigation.

One may not be in accord with the author's elimination of schizophrenic psychoses as an entity and their inclusion in a chapter entitled "Chaotic Sexuality," but it is well to learn his reasons for doing so. One may regard it an improper step to eliminate the psychoneuroses as a clinical group and to find so little organized discussion of their clinical types. Some may agree with the close identification of hysteria and malingering; others will object vociferously to the same. Probably no one will be completely satisfied with the Manual, yet each reader should find food for thought. Certainly, the author is sincere and careful in his statements, and from time to time one is particularly impressed by the excellence of his descriptive language.

(Continued on Page 20)

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BOOK REVIEWS

(Continued from Page 18)

For many the book will be of value for reference, to learn the details of tests and methods, and for numerous statistical data such as percentages, which are regularly recorded. The experienced psychiatrist will read the Manual with discriminative interest. The student of psychiatry should study the textbooks of other authors as well as the Manual, for the benefit of comparison of various psychiatric concepts, particularly those in reference to the psychoneuroses and other so-called "functional" mental disorders.

G. M.

TWENTY-FIVE YEARS AGO

(Continued from Text Page 248)

and every county society should be represented and every delegate in his place on the night of April 14 (Tuesday) at the Hotel Potter, Santa Barbara. Attacks upon medical men in the form of suits for alleged malpractice have increased enormously and reached serious proportions. Not one such suit was justified and not one was lost by us during the past year. Nor do our attorneys fear that such suits will go against us or be held to stand on appeal. But they cost money and time and trouble to defend, and if they are not carefully studied and defended, and verdicts allowed to go against physicians, there will be a perfect deluge of such actions and our profession will be mulcted of many thousands of dollars.

Then we shall have the question of fees under this insurance act and the manner in which practice is diverted, together with the relation of this cheap work to subsequent malpractice suits which the society will have to defend, a most serious question. Should a member who signs this fee contract be allowed to keep his membership, and if he is, should he be defended by the Society in case of a suit arising from such work? Do not fail to be at the meeting and let each county unit see to it that it elects delegates who will surely attend.

What construction shall be put upon the income tax and how will it affect our relations with our patients? Shall we notify them that the law requires us to sue for an account in order to prove that it is bad? Shall we establish a credit department in connection with the work of the State Society? There are certainly plenty of very important questions for the House of Delegates to consider.

⁂

Forty-Fourth Annual Meeting—Santa Barbara, Hotel Potter, April 14, 15, and 16, 1914—Railroad Rates.—The customary railroad rate of one and one-third fare, provided fifty or more are in attendance, will prevail. When you buy your ticket to go to Santa Barbara, pay the full fare and get a receipt-certificate. When you get to Santa Barbara, present this to the secretary to be signed and then when you get your return ticket hand this receipt to the agent and he will give you a return ticket for one-third the full fare. Do not fail to get the receipt-certificate or to have it signed by the secretary, for if you do, you have no redress. . . .

From an Original Article on "Some Remarks on the Industrial Insurance Act," by Frank P. Topping, M. D., San Francisco.—The evolution of the Industrial Compensation Act is interesting, to say the least; quite interesting from many angles. Interesting to the members of the medical profession, to the casualty and liability companies, to the workmen as individuals, and should be interesting to the various labor unions whose members will constitute the vast majority of all who will (or are supposed to) benefit by the Boynton Act—a law.

I trust my remarks will not prove offensive to the Industrial Accident Commission, whose members I believe to be working for a just interpretation and enforcement of the law. . . .

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It has been often stated (by persons who do not know) that there is a "Doctor's Trust"—a "Doctor's Union." Would that it were so, for thereby many of the hardships and much of the injustice resulting from this law could then be easily controlled and rectified. As a matter of fact, in San Francisco County there are (according to the last published official list of the state directory) 1,119 persons entitled to practice medicine, of whom 560 are members of the County Medical Society. With 50 per cent of the profession joined in an association, it would appear that some concerted action to secure justice to the medical profession could be taken. . . .

Why should you, Mr. Medical Man, visit a patient, say in an outlying district, in the interest of a prosperous dividend-paying casualty company with a large capitalization and reserve fund; with some of the highest salaried men as managers, resident agents, etc., in their employ for the paltry sum of $1.50 to save a human life? A visit that may take you from your practice for two or three hours. A visit that may save the company hundreds of dollars.

And why should you, Mr. Working Man, expect a first-class service to possibly save your life for the sum of $1.50? Do you hold your life so cheap? Do you regard the use of your right arm (on which you may depend to earn your daily bread) as worth $10 or $12.50? Are you not entitled to the best service obtainable? Yes? Then make the company who insures your employer obtain the services of men capable of giving you the treatment to which you are entitled, instead of the cheap service, based on the cut-rate, nonliving wage the company offers. Think this over, Mr. Working Man! . . .

Mr. Commissioner, the schedule contemplated by your board is far less than would be charged by any reasonable, capable medical man for the average working man. . . .

I think that the minimum fee is your idea, to govern all. It is not for you to revise our fee bill, nor to establish our fees. You have proposed the minimum (barring charity). Medical men as a class the world over do much work for nothing. No decent, self-respecting medical man ever refuses to treat the deserving poor without any thought of remuneration; nor refuses to administer to their ills; nor to answer calls at any reasonable hour of the day or night when occasion demands. To help them in many other little ways; to give but one class of service—the best in a man—is our privilege. But, Mr. Commissioner, there is a difference in this rate, and the rate that should be charged to a man earning at the minimum scale $3 per day, and ranging as high as $7 per day (and getting it). It is true that we treat some people for nothing. We are glad to do it and are proud of it. It is true that we reduce our fees in some cases, which we deem deserving, to an amount even less than the fee schedule proposed; but to expect us to enter into contracts with the large indemnity companies (who, by the way, are not in business for charity) or to treat cases for the state at these absurd rates is more than the average self-respecting practitioner should be asked to do. It is more than you have a right to ask, Mr. Commissioner! It is more than you have a right to demand, Mr. Insurance Man! It is not the service you are entitled to, Mr. Working Man! . . .

From an Original Article on "Some Sources of Error in Blood-Pressure Measurements," by Eugene S. Kilgore, M. D., San Francisco, with the Collaboration of W. H. Stabler.—Two years ago you appointed Dr. F. M. Pottenger, Dr. R. L. Wilbur, Dr. H. D. Power, and Dr. G. F. Reinhardt a committee to investigate the effect of athletics on the health of the participants. This paper contains a partial report of some work which was undertaken as an introduction to this problem at the Students' Infirmary in Berkeley under the influence of Doctor Reinhardt, the member of your committee at the University of California. Since blood pressure measurements occupy a prominent place in such investigations, it seemed primarily desirable to know how much they can be depended upon; particularly in comparative studies, how closely the observations of one person will parallel those of another. For the pres-

(Continued on Next Page)

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TWENTY-FIVE YEARS AGO

(Continued from Preceding Page)

ent, attention is limited to some of the ordinary types of instrument in use among practitioners. . . .

Summary.—The soft tissues of the arm give rise to little if any error in blood-pressure measurements. The resistance of hypertonic arterial walls has a greater influence, and perhaps at times produces large errors; although calcareous arteries may not give rise to an appreciable error. A cuff at least 12 centimeters wide should be used. Palpation and auscultation systolic readings have simplicity and definiteness to recommend them.

Experiments are reported which show the amount of variable error in palpation systolic readings for two observers. Similar experiments to show relation between palpation readings and auscultation readings for systolic pressure.

For diastolic pressure determinations the auscultatory method has the advantages of ease and definiteness of reading. Types of manometers are considered. Mercury instruments should not be used for oscillatory readings.

From an Original Article on "A Case of Hemoglobinuric Fever," by Dr. Harry B. Reynolds, Palo Alto.—Hemoglobinuric or "blackwater fever" occurs in the United States almost exclusively in the Southern States from Texas east, being most frequent in the lower Mississippi Valley.

Its occurrence in California is such a rarity as to warrant the report of the following case, which was seen by the writer in association with Dr. J. E. Chapin of Redwood City: . . .

From an Original Article on "Madelung's Deformity," by Howard F. Adler, M.D., San Francisco.—The condition known as Madelung's deformity or manus valga, as he chose to call it, is not only an extremely rare condition, but is also of interest because so few know that the same conditions which give rise to pes valgus or club foot, may cause an analogous deformity to the wrists.

Our first records to anything of the sort date back to 1825, when Begin first noted among adult male workers in the cloth factories of France, and especially those engaged in continuous heavy work with press levers, that there occurred quite often a painless, forward dislocation of the wrists. Nine years later rather indefinite reference was again made to this condition by the French surgeon, Dupuytren, to whom this discovery has wrongly been attributed by some, since we now know that in all probability all these cases were a form of professional deformity. From 1834 to 1878 there are about seven records of similar wrist subluxations, but, for various reasons, we cannot class them as typical Madelung deformities. . . .

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From an Original Article on "Intratracheal Anesthesia," by Saxton Pope, M.D., San Francisco.—This is the present stage of development of the intratracheal anesthesia apparatus in use at the University Hospital:

Its principal features are compactness, a means for the accurate regulation of the proportion of ether and air, electric heating to volatilize the ether, and, of course, the usual pressure and safety valve attachments.

The volume of air passing out of the machine is registered by a revolving float, bobbing up or down in a graduated glass cylinder—an idea adapted from Connell's apparatus.

Having the number of drops per minute and the liters of air per minute known, the percentage of ether can be determined. An average of 14 per cent per volume is required to maintain anesthesia.

The air is supplied either from an electric pump, a compressed air tank, or a foot bellows.

This apparatus has been used repeatedly for intratracheal anesthesia and has served its purpose most admirably.

From an Original Article on "Vaccination Against Tuberculosis *with Von Ruck Vaccine," by Frank Neall Robinson, M.D., Monrovia.*—For a number of years Dr. Karl von Ruck of Asheville, North Carolina, has been working along the line of immunization in tuberculosis. Ever since the introduction of the watery extract of tubercle bacilli (1897) his whole endeavor has been to improve this product, and to this end his studies have been in experimentation with the several component parts of the tubercle bacilli, and their action on the immunizing mechanism. When Bordet and Gengou first published their experiments in "Complement Fixation" he was among the first in this country to see the possibilities of it, and began experimenting with it in his work in his research laboratory. . . .

From an Original Article on "Treatment of Gonorrhea in the Female," by John C. Spencer, M.D., San Francisco. Before proceeding to the consideration of the subject named in the title, particular stress is laid upon making certain of the diagnosis of gonorrhea. The time-honored method of making a smear on a slide or cover-glass, then staining and demonstrating the presence of intracellular diplococci, will not stand the test of more modern methods of accuracy. Until within fairly recent times it has been customary to rely upon the Gram-stain as practically a specific diagnostic stain. This stain acts identically similarly with the micrococcus catarrhalis. As is well known, the latter organism morphologically so closely resembles the gonococcus that the two are only distinguishable culturally. . . .

From an Original Article on "Roentgen Rays and Mesothorium in Gynecologic Practice: Report on Their Application at Several German University Clinics from Personal Observation," by Henry J. Kreutzmann, M. D., San Francisco.—Before I start to narrate my observations on application of roentgen rays and of mesothorium in diseases of women, as I saw it at different German university women's clinics during a visit in October and November, 1913, I wish to make a personal remark.

Having enjoyed a good medical education, with excellent clinical facilities, it was natural for me all through my professional life as a physician to be rather conservative, to adhere to what I had learned during the time of my training as student and assistant physician. There is wonderful, rapid progress in the science and practice of medicine and I have endeavored to keep in line by reading good periodicals, by listening to good papers, by traveling and visiting the clinics and lectures of leading men. But I have always considered it a lack of fundamental medical education to rush to every new fad in medicine, to take up everything new that was placed before us as the thing, only to be dropped in a short time as worthless. . . .

From an Original Article on "Persistent Conjunctival Hyperemia After Cataract Extraction and Its Cause—Report of Six Cases, Illustrating This Condition," by

(Continued on Next Page)

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TWENTY-FIVE YEARS AGO

(Continued from Preceding Page)

P. de Obarrio, M.D., San Francisco.—In the course of some detailed observations in two series of fifty cataract extractions each, my attention has been called to the fact of a certain hyperemic state of the conjunctiva. It has been of rather frequent occurrence to observe a slight irritation after extractions, but of no serious nature. This congestion of the conjunctiva is of the nature you are apt to find in healing wounds, and in all cases it has subsided after the routine treatment of local applications, either of heat or cold, according to the time expired after the operation. I lay stress on this matter, for it is my object to call the attention to the fact that it is not to this physiological reaction, so to speak, that I am to refer, but to some persistent vasodilator disturbance of obstinate character appearing immediately after the surgical interference and existing for a more or less indefinite period. This symptom may or may not be accompanied with pain, but as a rule there is no pain whatever.

The general course of such a case, as I will immediately relate, will, I think, demonstrate better my point. . . .

From an Original Article on "Note on the Saturation Point of Serum for Normal Lipoids and Cholesterin," by Clarence Quinan, M.D., San Francisco.—Conclusions:

1. Pure cholesterin is very slightly, if at all, soluble in fresh bullocks' serum.

2. Esterification of cholesterin does not occur to any appreciable extent in fresh bullock's serum *in vitro.*

3. The saturation point of a serum for its own proper lipoids is only 0.1 per cent in excess of the normal content.

From an Original Article on "Report of a Case of Systemic Blastomycosis," by Harold P. Hill, M.D., and E. C. Dickson, M.D., San Francisco. — A certain amount of interest is attached to this case, insomuch as previously no case of systemic blastomycosis has been reported in California. We have had a number of infections with a type of fungus closely related but which differs in several characteristics from blastomycosis and which, with the exception of one case reported from Buenos Aires by Werincke, seems peculiar to California. In 1894, Gilchrist described the first case of blastomycetic dermatitis, and in 1902 it was recognized that the infection became generalized or systemic. Since Walker and Montgomery's report of that year, reports of systemic infection with blastomycetes have been frequently made, the large majority of these cases occurring in or around Chicago. The type occurring in California was first reported in 1894 by Dr. E. Rixford, and a full report of cases occurring to 1905 was given by Doctor Ophüls, who suggested the name "oidium coccidioides" for the organism. The clinical course of systemic blastomycosis and coccidioidal granuloma has a close similarity. The chief differences between the two types of infection consist in the mode of multiplication of the organisms and their channels of distribution. The blastomycetes multiply by budding; the oidiococcidioides by endosporulation. The former is distributed mainly by the blood, the latter by the lymph channels. It is not necessary to describe these organisms, their cultural characteristics or speculate as to their relationship. It is interesting to note that the case here described developed in California, where previously only coccidioidal granuloma had been found and was an infection with blastomycetes. . . .

From an Original Article on "A Case of Veronal Poisoning," by Edward Swift, M.D., Los Angeles.—The patient was a woman of forty-two years. She had always been in good health, but was of a highly neurotic temperament. At 11 a. m. I was called to see her, though I had seen her the night before, when she was apparently in perfect health but somewhat worried over some domestic troubles. I received the telephone call from her brother, who informed

(Continued on Page 26)

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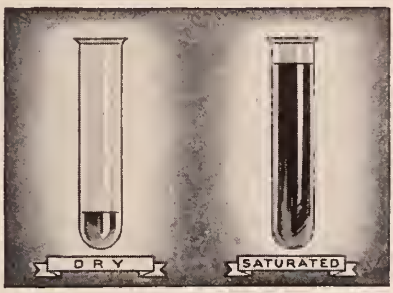

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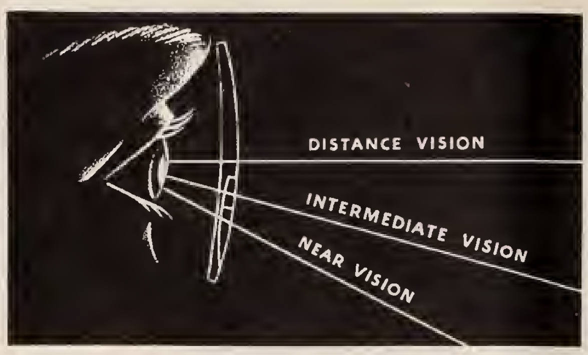

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TWENTY-FIVE YEARS AGO

(Continued from Page 24)

me that though his sister had gone to bed the previous night at ten o'clock, she had as yet shown no evidence of awakening. . . .

From Society Reports—"Proceedings of the San Francisco County Medical Society."—During the month of January the following meetings were held: . . .

Eye, Ear, Nose, and Throat Section.—January meeting: Dr. H. Y. McNaught in the chair.

Two cases were shown by Kaspar Pischel: first, a case of old iritis in which the anterior lens capsule showed whirls of sulci like finger-prints; second, a case of legal importance. The patient claimed that he had always seen well with both eyes, but that the sight of the left eye was destroyed by a piece of steel. The sight in that eye is diminished to counting fingers in the upper field of vision only. The ophthalmoscopic examination does not show any sign of injury but a congenital malformation of the disc. . . .

Dr. H. B. Graham exhibited a case of tumor of the nose and orbits, involving the middle third of the septum, the ethmoids and middle turbinates of both sides, the inner walls of the orbits and the orbital rim of both maxillary bones. There was exophthalmus, circular scotomata, slight papillitis and retinal hemorrhages in both eyes. The tumor was hard and in the nose presented a smooth, pale surface which bled easily. The x-ray showed no encroachment on the cranial cavity. The diagnosis lay between osteoma, osteosarcoma, and endothelioma. . . .

From "Resolutions Adopted by Los Angeles."—1. Resolutions in Regard to Fee Tables of Workingmen's Compensation Act.

WHEREAS, The State Industrial Commission, in order to carry out the provisions of the recently enacted Workingmen's Compensation Law of California, which is intended

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to safeguard the economic efficiency and prosperity of citizens engaged in industrial occupations, an object with which the ethical medical profession is in deep sympathy, as is evidenced by the service of its members in the past, in caring for many of the unfortunate sick without cost, in hospitals, dispensaries, and in private practice; and

WHEREAS, The State Industrial Commission of California, in order to carry out the provisions of the above law, has found it necessary to adopt a definite and fixed medical and surgical fee table in which minimum fees are enumerated, these fees being below those in general vogue among the ethical profession of this state; and

WHEREAS, The ethical medical profession has itself refrained from the adoption of arbitrary fee tables because it is difficult to make a fixed charge for services in the treatment of diseases and injuries, where the amount of skill and responsibility, both required and given, is a constantly varying factor, so that a fixed and arbitrary fee table could do injustice to both patient and physician; now, therefore, be it

Resolved, By the Board of Councilors of the Los Angeles County Medical Association (an organization established in 1871, and having more than six hundred ethical practitioners of medicine and surgery) that this Board, because of the above and other reasons, respectfully requests the California State Industrial Commission to pass a resolution and print on the fee table they have submitted, a statement to the effect that that Commission understands fully the difficulty and the inequality of an inelastic fee table for medical and surgical services, and that the minimum fees presented by the Commission are so made because of the limited resources of the State Industrial Insurance Fund, and because of the comparatively small financial income of the bulk of citizens, whom the Industrial Law is especially intended to protect and benefit; and be it further

Resolved, That it is the opinion of the Board of Councilors that some such resolution or statement of record by the California State Industrial Commission, should be made by that honorable Commission, lest, as time goes on, an injustice be done the very profession, which, above all

(Continued on Next Page)

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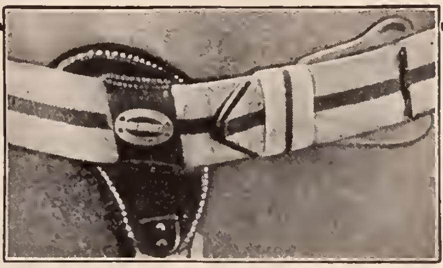

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TWENTY-FIVE YEARS AGO

(Continued from Preceding Page)

others in the past, has borne the brunt of aiding and helping the unfortunate sick and injured of our commonwealth. . . .

From "Medical Contracting by Wholesale."—The following proposed contract is published without comment and taken in connection with the list of those in the list of the Casualty Underwriters' Association, is sufficiently suggestive: Agreement for Medical Service, under the Boynton Act, made by George W. Goodale, M. D., to ——— Company. . . .

From "The Casualty Insurance Adjusters' Association of California," 533 Merchants' Exchange Building, San Francisco, California, February 2, 1914.—To Members: Re: Doctors and Hospitals.

Supplementing my previous circular letters, the following doctors have signed the Medical Fee Schedule, in addition to those already noted. . . .

BOARD OF MEDICAL EXAMINERS

(Continued from Text Page 248)

and on February 9, 1939, his license was revoked on each count.

Edward J. Buckley, M. D., was charged with aiding and abetting an unlicensed practitioner, *i. e.*, William Van Buren. On February 8, 1939, was found guilty and placed on probation for five years, provided that he cease practice on March 1, 1939, and that he shall not resume practice until July 1, 1939, and that he report at each San Francisco meeting during the period of his probation.

Clair W. Fulton, M.D., charged with use of fictitious name. On February 9, 1939, was placed on probation for five years, and to report at each Los Angeles meeting.

Walter C. Middleton, Drugless Practitioner, charged with practicing beyond the limitation of his certificate, was on February 9, 1939, placed on probation for three years. To report at each San Francisco meeting.

Milton F. Novotny, M.D., alleged addiction. On February 8, 1939, was placed on probation for five years, with the understanding that he cease practice immediately and not resume practice until August 1, 1939; that he not be permitted to apply for or have a Federal narcotic permit or have narcotics in his possession.

Harvey Smith, M.D., based on record of conviction of driving while intoxicated, was on February 9, 1939, placed on probation for a period of five years, with the understanding that he abstain from all alcoholic beverages and report at each Los Angeles meeting.

Joseph T. Wrenn, M.D. Charged with aiding and abetting an unlicensed practitioner, *i. e.*, William Van Buren. License was revoked on February 8, 1939, provided that if he immediately file a stipulation with the Board that he would not aid or abet an unlicensed individual, nor advertise other than by the use of the ordinary business card, said revocation would be set aside and he would be placed on probation for a period of five years, he to report at each San Francisco meeting. Stipulation filed February 8, 1938.

William H. Young, M.D., charged with (1) aiding and abetting, (2) use of fictitious name, in connection with the so-called Samaritan Treatment for Alcoholism, San Francisco Branch, was on February 9, 1939, found guilty of both charges and his license revoked.

* * *

Approximately seventy applicants, comprising physicians and surgeons, chiropodists, and drugless practitioners, wrote the regular examination.

News

"The Appellate Division of the Supreme Court of New York handed down a decision on January 11, upholding the refusal of the Board of Regents of the University of

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the State of New York to endorse the Italian license or diploma to practice medicine of Dr. Gustave G. E. de Luca. The Board refused to endorse the license on the ground that there is great uncertainty whether the standards of the European institutions today are comparable to what they were when the law was enacted which gives the Commissioner and the Board of Regents the right to endorse foreign licenses without examination. The Board offered the petitioner in this case the opportunity to take the licensing examinations." (*Journal of the American Medical Association,* February 4, 1939, page 455.)

Under the caption "Medicine" the magazine *Time,* issue of February 13, 1939, page 38, printed an interesting article headed "Refugee Physicians." Therein is related that before the reign of Hitler there were 50,000 physicians in Germany; that since 1933 non-Aryan doctors have been gradually pushed out of practice. "The crowning blow came last October when the licenses of all Jewish physicians were revoked. . . . Although Germany now faces a shortage of trained physicians and has been compelled to reduce the period of medical education by two full years, more than half of the ostracized Jewish physicians still remain in Germany, helpless and impoverished. . . . Most of those physicians lucky enough to escape have come to the United States."

"An 'underground railroad' to a doctor's office, where illegal operations were allegedly performed was described by a 13-year-old girl, found recently in her San Pedro home in a critical condition. As a result of the asserted operation, according to Juvenile Officer L. R. Howsley, six persons are being investigated as possible operators of the 'system.' Howsley said the girl complained to her mother of illness on January 16 and the parent was told by a San Pedro doctor that her daughter was to become a mother. A few days later, without knowledge of the physician, according to the girl's story, the illegal operation was performed and she was taken to her home to recover. Alarmed by the girl's critical condition, the mother was reported to have summoned still another doctor who treated her and reported the case to police. Howsley said the mother admitted that friends told her how to contact certain persons to bring about the operation. It was declared by the mother and girl that they were driven in an automobile through the night by a devious route, winding about and back-tracking along country roads and through city streets to the place where the operation was performed. . . . He (Howsley) stated his department was waiting until the girl recovers before attempting to fully identify members of the 'ring'." (San Pedro *News-Pilot,* January 31, 1939.)

"Accused of practicing medicine without a license, Dick Smith, thirty-nine, was arrested here last night. With him was jailed Susie King, thirty-two, assertedly his assistant. They were arrested by city police on a misdemeanor warrant issued in Firebaugh. Smith was taken to Firebaugh to face the charges by Thomas P. Hunter, special agent of the State Medical Board of Examiners. Miss King was given a suspended sentence on a vagrancy count here on the condition she leave Merced. According to Hunter the pair was treating cotton camp laborers in the Firebaugh district in Madera and Fresno counties with herbs. Hunter said Smith was unable to read or write and Miss King served as his secretary." (Stockton *Record,* February 3, 1939.)

"Donald W. Bell, thirty-five, Watsonville Chiropractor accused of giving Mike Jurich a $5.00 bad check, was arraigned Saturday morning before Police Judge Miller Chandler and will have preliminary hearing at 10 a. m. Monday." (Watsonville *Register Pajaronian,* January 28, 1939.)

"Two men and two women, all indicted by the grand jury last November for conspiracy to violate the Business and

(Continued on Page 31)

Bequest Forms: Unto the California Medical Association*

FORM OF CLAUSE OF WILL PROVIDING FOR CASH BEQUEST

I hereby give and bequeath unto Trustees Of The California Medical Association, a nonprofit corporation of California, the sum of $——— to be known as the ——— Gift, to be used and expended by said corporation for scientific, educational, or hospital purposes.

* * *

FORM OF CLAUSE OF WILL PROVIDING FOR CASH BEQUEST

I give and bequeath unto Trustees Of The California Medical Association, a nonprofit corporation of California, the sum of $———, to be held as a fund, to be known as the [here insert name desired] Fund, the principal whereof shall from time to time be invested to the best advantage compatible with safety, and the income whereof shall be used and applied for scientific, educational, or hospital purposes.

* * *

FORM OF CLAUSE OF WILL PROVIDING FOR BEQUEST OF PERSONAL PROPERTY

I give and bequeath unto Trustees Of The California Medical Association, a nonprofit corporation of California [here describe the property], the same, or the proceeds thereof, to be held as a perpetual fund, to be known as the [here insert name desired] Fund, the income whereof shall be used and applied for scientific, educational, or hospital purposes. The said corporation shall have the power to sell said property and to invest and reinvest the proceeds arising from the sale thereof from time to time as it may deem advisable for the purpose of producing as large an income as may be compatible with safety.

* * *

FORM OF CLAUSE OF WILL PROVIDING FOR DEVISE OF REAL PROPERTY

I give and devise unto Trustees Of The California Medical Association, a nonprofit corporation of California, to aid and further its scientific, educational, and hospital purposes, and to be known as the ——— Gift, the following described real property situate in the County of ———, State of California, and more particularly described as follows, to wit:

* * *

FORM OF CLAUSE OF WILL PROVIDING FOR DEVISE OF REAL PROPERTY

I give and devise unto Trustees Of The California Medical Association, a nonprofit corporation of California [here describe the property], the same, or the proceeds thereof, to be held as a perpetual fund, to be known as the [here insert name desired] Fund, the income whereof shall be used for and applied to the support and maintenance of scientific, educational, or hospital purposes. The said corporation shall have the power to sell said property and to invest and reinvest the proceeds arising from the sale thereof from time to time as it may deem advisable for the purpose of producing as large an income as may be compatible with safety.

---

* These Bequest Forms were discussed editorially in CALIFORNIA AND WESTERN MEDICINE, for March, 1936, p. 145, and June, 1936, p. 460.

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BOARD OF MEDICAL EXAMINERS

(Continued from Page 29)

Professions Code of California, pleaded guilty and asked for probation in Superior Judge Jacks' Court recently. Thomas F. Huston, 1153 Bush Street; John A. Stevens, Ruth Nielson and Juanita Butcher, were indicted on eleven counts, including practicing medicine without a license. Judge Jacks set the probation hearing for February 28." (San Francisco *Chronicle*, February 3, 1939.) Reports of the Investigation Department indicate the individuals mentioned were operating what was known as the Samaritan Treatment for Alcoholism at 1153 Bush Street, San Francisco.

"An appeal has been made by the Police Commission to the City Attorney for a ruling on the extent of its powers in regulating massage parlors in Los Angeles. . . . Questioning the legal aspects of permitting one group of masseuses to treat the opposite sex and not another, where neither held State medical licenses, the board decided to ask the City Attorney to pass on the question. Captain Starritt also assailed numerous institutions where those taking up massage for a livelihood study and obtain 'diplomas'. He said that such certificates have no real value since the State itself has established no standards of the profession." (Los Angeles *Times*, February 6, 1939.)

"Dr. Louis Kameny, convicted of conspiracy to commit grand theft in connection with an insurance fraud, was released from the balance of his three years' probation yesterday by Superior Judge Lincoln S. Church. Doctor Kameny, through his attorney, Leo Sullivan, pleaded that he wished to appear before the State Board of Medical Examiners with a clean slate, in order to petition for the return of his license, ordered revoked after his conviction in December, 1937. . . ." (Oakland *Tribune*, February 5, 1939.)

"The San Francisco County Grand Jury spent more than three hours last night listening to testimony in the abortion-death of Mrs. Betty Barsotti, twenty-four, who died at Franklin Hospital, February 6. Before her death, Mrs. Barsotti told police she had had an abortion in a 'house on Cortland Avenue,' the exact location of which she was not certain. Chief witnesses were Dr. Reginald Grant, who treated her at the hospital before her death, and Eugene Aureguy, private investigator, who was a principal figure in the Constance May Gavin-Flood case. After Doctor Grant had testified to her death, Aureguy told Assistant District Attorney Harry J. Neubarth he had been retained by the physician to investigate the case, immediately after Mrs. Barsotti entered the hospital." (San Francisco *Chronicle*, February 9, 1939.)

"In announcing that he plans to speed the administration of justice during his régime as attorney general, former Governor Frank Murphy of Michigan said: 'Delay is often as good as winning a criminal case.' Therein the new attorney general has put his finger upon one of the glaring defects in our judicial system. Delay is a device always resorted to by those who make a business of defending criminals. It opens a detour marked with light sentences or no sentences and avoids the highway that should be the lot of the confirmed criminal—adequate, swift and certain punishment. . . . If Attorney-General Murphy is successful in speeding up justice, he will be a knight in armor to all those fighting the battle against crime." (Editorial, Sacramento *Bee*, January 31, 1939.)

"A golden shovel bit into soft earth at California and Maple streets yesterday to signalize beginning of construction on the new $350,000 Hahnemann Hospital. Dr. James W. Ward, dean of the homeopathic medical profession in San Francisco and founder of the Homeopathic Foundation of California, builders of the hospital, turned the first spade-

(Continued on Page 34)

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OFFICIAL JOURNAL OF THE CALIFORNIA MEDICAL ASSOCIATION

VOL. 50 MARCH, 1939 NO. 3

California and Western Medicine
Owned and Published by the
CALIFORNIA MEDICAL ASSOCIATION
Four Fifty Sutter, Room 2004, San Francisco, Phone DOuglas 0062

Address editorial, business and advertising communications to Dr. George H. Kress as per address above.

EDITOR . . . . GEORGE H. KRESS

Advertisements.—The Journal is published on the seventh of the month. Advertising copy must be received not later than the fifteenth of the month preceding issue. Advertising rates will be sent on request.

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Subscription prices, $5 ($6 for foreign countries); single copies, 50 cents.

Volumes begin with the first of January and the first of July. Subscriptions may commence at any time.

Change of Address.—Request for change of address should give both the old and the new address. No change in any address on the mailing list will be made until such change is requested by county secretaries or by the member concerned.

Responsibility for Statements and Conclusions in Original Articles.—Authors are responsible for all statements, conclusions and methods of presenting their subjects. These may or may not be in harmony with the views of the editorial staff. It is aimed to permit authors to have as wide latitude as the general policy of the Journal and the demands on its space may permit. The right to reduce or reject any article is always reserved.

Contributions—Exclusive Publication.—Articles are accepted for publication on condition that they are contributed solely to this Journal. New copy must be sent to the editorial office not later than the fifteenth day of the month preceding the date of publication.

Contributions—Length of Articles: Extra Costs.—Original articles should not exceed three and one-half pages in length. Authors who wish articles of greater length printed must pay extra costs involved. Illustrations in excess of amount allowed by the Council are also extra.

Leaflet Regarding Rules of Publication.—California and Western Medicine has prepared a leaflet explaining its rules regarding publication. This leaflet gives suggestions on the preparation of manuscripts and of illustrations. It is suggested that contributors to this Journal write to its office requesting a copy of this leaflet.

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EDITORIALS[†]

CALIFORNIA PHYSICIANS' SERVICE—INCORPORATED ON FEBRUARY 2, 1939

Names and Symbols.—"California Physicians' Service," or "C.P.S.," as a name and symbol will soon sound as familiar to Doctors of Medicine as "California Medical Association," or "C.M.A." For, on February 2, 1939, the Articles of Incorporation of California Physicians' Service (which appeared on page 134 of last month's issue of California and Western Medicine) were filed with the Secretary of State of California, and the first Board of Trustees of the new corporation was elected by the administrative members. The California Medical Association Council[*] having previously, on January 14, 1939, taken the necessary steps to enable the new medical service promptly to assume its work, its board of directors, to be known as the Board of Trustees, met on February 4, 1939, and elected the following officers: President, Ray Lyman Wilbur; Vice-President, Lowell S. Goin; Vice-President, C. Kelly Canelo; Secretary, Alson R. Kilgore; Assistant Secretary, T. Henshaw Kelly; Treasurer, Alson R. Kilgore; Assistant Treasurer, T. Henshaw Kelly.

They appointed Morton R. Gibbons, Sr., M. D., San Francisco, as Medical Director, and A. W. Widenham of San Francisco as General Manager.

The Trustees, according to the By-Laws, appointed an Executive Committee consisting of T. Henshaw Kelly (Chairman), Samuel Ayres, Jr., and Alson R. Kilgore.

The new organization has established its central office in San Francisco, where it may be addressed: California Physicians' Service, 602 Mills Building, 220 Montgomery Street, San Francisco, or communicated with by telephone: EXbrook 3212.

* * *

Explanatory Brochure and Registration Blanks.—Before this issue of California and Western Medicine is placed on the desks of members of the California Medical Association, it is expected that an explanatory brochure, prepared by the California Physicians' Service Executive Committee (containing abstract of by-laws and other needed information*) will have been received by every doctor of medicine licensed to practice in California. With this pamphlet will also be sent a registration blank. Every California Medical Association member, therefore, is requested to read carefully the contents of the brochure, and to send the registration blank to the California Physicians' Service, as promptly as possible, at the address given above. An appreciated service will likewise be rendered if every member of the Association will constitute himself a Committee of One to urge other members to do the same.

[†] Editorials on subjects of scientific and clinical interest, contributed by members of the California Medical Association, are printed in the Editorial Comment column which follows.

[*] See California and Western Medicine, February, 1939, Council minutes, Item 17, on page 133.

In addition, members of the California Medical Association who are acquainted with nonmembers of the California Medical Association are requested to suggest to such physicians that they also mail their registration replies to the Mills Building office

* * *

Coöperation in Prompt Reply Will Be Appreciated.—This coöperation may be of real value because, at the present time, the California Legislature is in session and has under consideration certain compulsory health insurance bills. Prompt approval, by the entire medical profession of the State of California, of the California Medical Association's voluntary plan of medical service on a periodic payment basis will be an important indication to the legislators that the voluntary plan of so-called health insurance has the whole-hearted support of the thousands of licensed physicians of California; to whom the State and its people are much indebted for many years of altruistic service in the promotion of activities designed to conserve health and life, and whose intimate knowledge of the incidence of disease should make their opinions worthy of most careful consideration by all groups and individuals who profess interest in the betterment of the health of the people.

* * *

Reaction of the Public as Shown in the Press. The reaction of the people of California to the statewide, voluntary medical service plan proposed by the California Medical Association, in so far as it has been reflected in editorial and other articles in the daily and weekly newspapers of California, has been revealed in part to readers of CALIFORNIA AND WESTERN MEDICINE through the excerpts which have appeared in the Press Clippings columns of the OFFICIAL JOURNAL's latest issues. Because it is important for members of the medical profession to evaluate properly the reaction of the public to the proposed medical service plans, the attention of readers is again called to the quotations given, even though it may seem strange to some physicians to find that kind of reading matter in the pages of a medical publication. However, it must never be forgotten that CALIFORNIA AND WESTERN MEDICINE is primarily the official publication of organized medicine in California, and in that capacity cannot evade its responsibility to present to its reading clientele all important information pertinent to the interests of medicine, both organized and scientific.

* * *

Future Communications from California Physicians' Service.—Henceforth, official communications from California Physicians' Service will be sent out from the offices of that corporation; although at all times the pages of CALIFORNIA AND WESTERN MEDICINE will be available for additional publicity. For easier reference, such items in future issues will be placed under the caption, "California Physicians' Service."

* * *

A United Front Should Now Be in Evidence. In the meantime, it is to be hoped that all members of the California Medical Association will give to the Association's medical service plans, as expressed in "California Physicians' Service," the fullest possible support. Granted that there may be members of the State Association who prefer to be proponents or protagonists of a system of compulsory health insurance, it certainly would seem a proper course of conduct for such physicians not to appear before mixed audiences in advocacy of compulsory health systems, but, rather, to bide a bit with their promulgations until the new voluntary system espoused by their fellows through their official organization has had an opportunity of being tried out in practice.

In short, since the members of the California Medical Association, through their constituted authorities, the House of Delegates and Council, have embarked upon the institution of a state-wide voluntary medical service plan to which much publicity has been given, from one end of the United States to the other, it now behooves every one of the more than six thousand State Association members and the component county medical societies to give the fullest possible support in carrying the plans through to successful issue. This is not too much to ask, and that much is expected from one and all.

CALIFORNIA ADMINISTRATION COMPULSORY HEALTH INSURANCE BILLS—
A. B. 2172 AND S. B. 1128

A Voluntary Medical Service Plan Is Preferred by the Medical Profession.—A voluntary medical service plan has been espoused by the California Medical Association. The inference, therefore, is clear, that a voluntary system of so-called health insurance is preferred by members of the medical profession of California rather than a compulsory health insurance system, supported, as it would need to be, through taxation, and administered by public or political agencies.

* * *

The So-Called "Administration Health Insurance" Bill.—Prior to the State election on November 8, 1938, considerable publicity was given by some of the candidates for office to proposed health insurance legislation; and the press recurrently printed news items concerning the proposed "Administration Health Insurance" law. Little more than rumor, however, was forthcoming, until January 25, when Assembly Bill 2172 and its companion Senate Bill 1128 were submitted to the lower and upper chambers of the California Legislature. In their titles, the two bills state they relate "to a system of health insurance within the system of unemployment reserves," and, further, that they are acts "to establish a system of social insurance," and that these acts "shall be known and may be cited as the Social Insurance Act."

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* On page 247 of this issue of CALIFORNIA AND WESTERN MEDICINE, the series of questions and answers concerning California Physicians' Service, which appear in the brochure, are given place as part of the Official Journal's permanent record concerning initial steps in the organization of the new corporation.

Article 11, Section 151, states that "The provisions of Articles 11 and 16 of this act establish and provide for a plan of compulsory health insurance *integrated* [italics by Editor] with the system of unemployment insurance, together with plans of voluntary health insurance for which provision is made herein."

It is not possible, at this time, to go into extended discussion of the two measures. They may be said, however, to have been put forward by the various California groups and advisors who have espoused compulsory health insurance as the cure-all for the large amount of so-called, inadequately cared-for illness—be the same imaginary or otherwise—which some of the lay adherents of the plan so often and so vociferously claim does exist.

Members of the Association who wish to acquaint themselves concerning the details of the proposed law should write to the California Supervisor of Documents, 214 State Capitol, Sacramento, requesting a copy of A. B. 2172 or of S. B. 1128. An equally interesting measure is Senator Hollister's proposed law (S. B. 551) which would provide for a medical service plan somewhat more in line with legislative drafts that have come out of Washington, D. C.

* * *

Excerpts From the Bill Are Printed in This Issue.—For the information of readers of the OFFICIAL JOURNAL, Article XV, "Organization of Medical Services," and Article XVI, "Administration," are given in this issue of CALIFORNIA AND WESTERN MEDICINE, on page 211. These are worthy of perusal and careful thought.

At the present time all indications point to a legislative battle concerning these bills. Members of the Association, therefore, are urged to remain alert to the subject and to familiarize themselves with the issues at stake. And this, for the good and sufficient reason that the standards of scientific medicine and medical practice in the proper care of citizens and for the public health are all here vitally involved.

* * *

Past Experience and Clear Thinking Worthy of Consideration.—It may not be amiss for an individual, or a group of individuals, to ponder on generous and altruistic abstractions; but precipitately to transform such theories into law might work untold havoc on the very persons whom the theoretical plans were aimed to help. The past record of achievement in public health advancement, under evolutionary systems of medical practice, combined with the practical common sense and capacity recognizing, when illness actually does exist, that its real elimination needs primary attention to the causes rather than to the symptoms or end-results—these are elements that must continue to be taken into fundamental consideration by those who would ameliorate deficiencies of medical care. More than well-meaning phraseology is needed.

The enactment of a law, no matter how well-intentioned, may be of little avail if, in its administration, the ends desired are not attainable. In the last analysis, the values of things are judged by their end-results.

CALIFORNIA MEDICAL ASSOCIATION'S 1939 ANNUAL SESSION—MAY 1–4

Del Monte Annual Session Almost at Hand. With the sixty-eighth annual session of the California Medical Association distant but a brief two months, it may not be out of place to state that the Hotel Del Monte, the Association's next place of meeting, has been the scene of many notable gatherings of the past; and that its selection for the annual reunion practically always receives the hearty approval of members, as is evidenced by the large number who betake themselves to the Monterey Peninsula whenever that picturesque corner of the State is chosen as the place of reunion.

* * *

Programs of Scientific Sections Have Been Completed.—The California Medical Association Committee on Scientific Work, in conference with the Section Secretaries, agreed upon the arrangement of the complete program at a meeting held in January, and the Section Secretaries have been busily engaged in securing the abstracts of papers to be printed in the Annual Session Supplement that will be a part of the April issue of CALIFORNIA AND WESTERN MEDICINE.

* * *

Hotel Reservations.—Hotel rates appeared on pages 137–138 of the February number. In this current issue, additional information may be found concerning auto courts.* Members who plan to be in attendance, therefore, are advised to make hotel reservations in advance. As a matter of fact, some far-sighted members wrote for their reservations within a week or two after the annual session of the past year.

* * *

Scientific Exhibits and Films Requested.—The Committee on Scientific Work will welcome additional participants in the Scientific Exhibits and the Medical Films programs. All members who have such possible contributions, and who have not yet communicated with the Association Secretary in regard thereto, are urged to do so at once, indicating the nature of their exhibits, and space required; and concerning films, the titles and time required, together with any additional information likely to be needed.

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* See page 213.

The full program of the Annual Session will appear in a Supplement to the April issue of California and Western Medicine.

CALIFORNIA LEGISLATURE—FIFTY-THIRD SESSION

Constitutional Recess Is Over on March 6.—By March 6, the State Assemblymen and State Senators who, during the February constitutional recess, have been sojourning in their respective home districts, to confer with constituents concerning the 2,768 Assembly bills, sixty-eight Assembly constitutional amendments, sixteen Assembly concurrent resolutions and twenty-nine Assembly joint resolutions introduced into the Lower Chamber, and the 1,227 bills, twenty-four constitutional amendments, nine concurrent resolutions, and fourteen joint resolutions submitted to the Senate, will once more be in Sacramento, to convene and carry on their law-making labors, probably into May or June.

* * *

Former and Present Days: In Relation to New Laws.—The daily lives of physicians in the care of sick and injured persons are ordinarily far removed from the sphere of statute drafting. Indeed, in days gone by, legislatures came and went with little or no influence upon the professional, economic or social welfare of medical men, except, perhaps, in the matter of taxes, or minor amendments to public health matters or a medical practice act. Not so today, however!

* * *

California Medical Association's Committee on Public Policy and Legislation.—In recent years, the duty of keeping check on the mass of proposed laws submitted at each biennial session of the California Legislature has become little less than a very onerous task, the burden of which has largely fallen upon the shoulders of the Chairman of the Committee on Public Policy and Legislation, Dr. Junius B. Harris of Sacramento, and the coworkers his committee has found it necessary to draft into coöperative service.

Eternal vigilance is not only a motto for the Committee on Public Policy and Legislation, but it must be constantly kept in view and practiced, because every one of the hundreds of bills must be carefully scrutinized, if undesirable inclusions, having implications to public health and medical practice activities, are to be detected.

* * *

List of Bills Worthy of Perusal.—On page 213, in this issue of California and Western Medicine, appears a classified list of the many Assembly and Senate bills in which members of the medical profession cannot have other than a natural and a live interest. Every member, consequently, should turn to that list and note for himself the magnitude of the labor given to some of the Association's officers, when those officials are asked not only to discover improper provisions in new measures when they are presented in the January session, but to watch, each and all, for obnoxious additions or modifications of the proposed laws, as they pursue their tortuous and checkered progress in Assembly or Senate committees (where actual presence of the California Medical Association's representatives is not infrequently necessary to counteract the arguments of spokesmen for the opposition or specious interests).

* * *

How Coöperation May Be Given.—The presentation of this subject, along the above lines, is intended to remind our members of the generous service rendered by certain Association officers, to the end that, when appeal for coöperation is made by the Committee on Public Policy and Legislation, the aid requested may be cheerfully and promptly given.

Also, to again call the attention of all, on behalf of the Council, to the unwisdom of component county societies, or of individual members, in passing resolutions or espousing certain proposed statutes, and giving copies of such actions to the proponents of the submitted measures.

The Council of the Association and the Committee on Public Policy and Legislation are glad to know the views of component county societies and of members, but request that such expressions of opinion be forwarded through the Central Office of the California Medical Association. Otherwise, well-meant resolutions and commendation may be brought to the front, for the first time, in Assembly or Senate committee hearings, to become, at times, real sources of embarrassment to the California Medical Association Committee on Public Policy and Legislation. Surely, all must agree that the Committee on Public Policy has more than its share of exacting service, without adding unnecessarily to its labors.

LIBRARY BEQUEST TO LOS ANGELES COUNTY MEDICAL ASSOCIATION

Walter Jarvis Barlow, M. D.—The late Dr. Walter Jarvis Barlow, who on September 4, 1937, passed on from his earthly labors, was ever occupied throughout a very busy professional life in Los Angeles in altruistic endeavor for his fellow citizens. Himself a victim of pulmonary disease, he originated and placed on a sound foundation the Barlow Sanatorium of Los Angeles; so named, by friends, as was the Barlow Medical Library, because his colleagues and coworkers felt that his name should be associated and perpetuated with the outstanding activities he had been instrumental not only in bringing into existence, but in firmly establishing. It was the Editor's privilege, as Faculty Secretary of the University of Southern California's College of Medicine, at a time when Doctor Barlow was Dean, to have been intimately associated with this colleague, who never tired in unostentatious efforts for both his fellows and the profession he so aptly represented. His was primarily a love of service, as was shown when the

Los Angeles County Medical Association proposed to erect a permanent headquarters and library building, even though the Society itself had no books to place therein. At that time Doctor Barlow promptly gave his consent to the removal thither of the Barlow Medical Library, and also to its change of name to Library of the Los Angeles County Medical Association.

Although Doctor Barlow's death occurred in 1937, it was not known until the beginning of the present year that he had remembered the Library of the Los Angeles County Medical Association in his will, the Association receiving, as the first notice of his bequest, a letter with check stating payments for a similar amount would be forwarded quarterly. The excerpt from Doctor Barlow's will, having to do with this legacy, appears in this number of California and Western Medicine, in the Letters department, on page 236.

* * *

Bequest Forms in This Issue of the Official Journal.—With the thought in mind that types of bequest might have a suggestive value to members of the California Medical Association, who may desire to bequeath property, real or personal, to activities designed to promote general or special lines of work in scientific medicine, we prepared several years ago, with legal advice, such convenient forms, and they have since regularly appeared in California and Western Medicine—being printed, in this issue, on advertising page 30. They are again called to the attention of members of the Association in the hope that the example set by the late Morris Herzstein of San Francisco (the income of whose bequest to the California Medical Association is defraying the cost of the cancer exhibit at the Golden Gate International Exposition), and that of the late Walter Jarvis Barlow, in his handsome gift to the Los Angeles County Medical Association for its library, may lead others to think of endowments that would work for the betterment of scientific medicine and so to the advancement of public health.

Other State Association and Component County Society News.—Additional news concerning the activities and work of the California Medical Association and its component county medical societies is printed in this issue, commencing on page 210.

Belie in yourself the weaknesses of your country. Water partakes of the qualities, good or bad, of the seams through which it flows; and man of the climate into which he is born. Some owe more to their country than others because a happier zenith lay above them. There is no nation, even of the most cultured, without some inborn defect which its neighbors will not at once strike upon, either for their caution, or their comfort. A commendable skill to eradicate such national weaknesses in yourself, or at least to hide them; thus are you made unique among your kind, for what is least expected is esteemed most highly. There are weaknesses also of race, of rank, of profession, and of age, which, if gathered together in one individual, and not curbed, yield an intolerable monster.—Baltazar Gracian, 1653.

EDITORIAL COMMENT†

NEED FOR ADDITIONAL HOSPITAL RESIDENCIES

This is an age of specialization, and only those who have mastered thoroughly the essentials of a certain branch in a certain calling can hope to achieve any success in life. This is particularly true in medicine where, because of the rapid strides made in that greatest of human sciences, specialization is at its zenith. Indeed, the term "physician and surgeon" has come to mean nothing but mere names which designate membership in a certain class, but poorly defines the professional status of that member in his respective field. Anyone who has watched carefully the present trends in specialized service must come to the conclusion that the general designation of "physician and surgeon" will soon give place to a specific title which will clearly define the professional status and equipment of the title bearer. The kind of diplomas and certificates issued by medical schools and state boards will then be more varied; and just as in teaching we have a kindergarten certificate, a grade-school certificate, a junior or senior high-school certificate, and a junior-college certificate, so in medicine we shall have, in addition to the general certificate, a great variety of other certificates, each revealing the particular branch of service which a certain certificant is qualified to render.

Since such a division in rendition of services is inevitable, it is well to inquire what plans are being made by our educational medical institutions, hospitals included, to provide opportunities for young graduates in medicine and surgery to obtain specialized training in the various branches of the profession. From my own study of the subject, I am convinced that the opportunities for postgraduate training are very limited in scope and woefully inadequate to meet the needs of the aspirants for specialized service. The believer in the noble democratic principle of *La carrière ouverte aux talents* is rudely shocked to discover that, in a profession so important to human welfare as medicine, the finest talents are not always given a chance to develop themselves and attain perfection in any particular branch.

It is not necessary for me to enter into a detailed study of conditions as they exist in the entire United States. It is sufficient for the purposes of this paper to present the situation in California, where I have lived, studied and worked for the greater part of my young life, and I may well assume that the same conditions are paralleled elsewhere with but slight modifications.

The four recognized medical schools in the State of California turn out each year 279 graduates in medicine, distributed as follows: University of California, 61; College of Medical Evangelists,

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† This department of California and Western Medicine presents editorial comments by contributing members on items of medical progress, science and practice, and on topics from recent medical books or journals. An invitation is extended to all members of the California Medical Association to submit brief editorial discussions suitable for publication in this department. No presentation should be over five hundred words in length.

111; University of Southern California, 44; Stanford University, 63. Every one of these graduates would have been glad to continue postgraduate studies in a specialized field for a period of one to three years, but, unfortunately, there are only fifteen hospitals in the state that provide opportunities for specialization, classified in service as follows: internal medicine-general, 14 hospitals; cardiology, 0; communicable diseases, 2; tuberculosis, 8; malignant diseases, 1; pediatrics, 9; neurology, 1; psychiatry, 4; dermatology and syphilology, 2; obstetrics and gynecology, 6; general surgery, 15; neurosurgery, 1; thoracic surgery, 1; anesthesia, 0; orthopedic surgery, 5; urology, 4; ophthalmology, 3; otolaryngology, 4; pathology, 6; radiology, 4; physical therapy, 1. Total number of possible openings available in the fifteen hospitals, 91.

If each of these hospitals were to change its resident staff every year, ninety-one interns, or one-third of the graduating classes, could be accommodated. However, once an intern secures a residency in any specialty, he prefers to stay at least two to three years in the same place, as that is considered the minimum time required for specialization. That makes possible for only 15 per cent of the graduating classes to obtain any kind of a residential position. It is no wonder, then, that resort is had to "wire pulling" in order to obtain by insidious influences what cannot be gotten by sheer merit.

We are all heartily in accord with the general proposition that the object of medical education is to promote the public welfare. No principle is, from the ideal standpoint, more sacred to a well-governed democracy than the principle of open and universal opportunity to all, without distinction as to race or creed, and an equal chance to those possessing similar capacities and talents for individual growth and achievement. But what practical means shall be adopted to carry into execution certain high principles and ideals is a problem which requires immediate solution.

In my mind this baffling problem can be solved satisfactorily by making fuller use of the smaller county hospitals, following in that the example set by teacher-training schools which use the smaller public schools to train the future teachers in our secondary system of education. Thus California, with a population of over six million, is divided, for purposes of administration, into fifty-eight counties. The latest Hospital Number of the American Medical Association lists a total of fifty-two county hospitals in California, showing that nearly every county has its own hospital. It must, however, be regretfully noted that only nine county hospitals are approved for training interns, and of these nine only seven are approved for residencies in specialties. It must further be noted that of the seven hospitals so approved, only two, namely, the Los Angeles and the San Francisco county hospitals, offer a wide diversification of specialty training; the other five hospitals, namely, Fresno, Alameda, San Bernardino, San Diego, and Santa Clara county hospitals, offer facilities for training in only two or three specialties.

What would be the effect of granting recognition to all county hospitals by including them in the approved list of such an organization as the American College of Surgeons? To this question the only answer usually given is that every hospital must conform to certain standards in order to obtain recognition, and it is claimed that no acorn should be allowed in a forest of full-grown oaks. To such objections the answer must be made that in the case of governmental institutions the standards must be so flexible in their application as to permit a gradual remedying of certain defects and shortcomings. There is a general misunderstanding regarding the nature and function of a small county hospital. I, myself, when I first took up the work in a small nonapproved county hospital immediately upon the completion of my internship in a big teaching hospital, had certain misgivings regarding its *raison d'être*. However, when I gained better insight into the spirit which animates the existence of a small county hospital, I found that the retarded development of the county hospital was due to its inability to keep pace with the too rapid shift from a dominantly agricultural to an urbanized society. I have also found that the communities in which such small hospitals are located are most eager to make rapid adjustments in their relation to the new order of things, to adopt the latest methods of progress, and to raise the standard of their civic institutions to such levels as the community's economy will permit. Thus, in the county hospital where I am now employed, one finds, in an old-style structure, the most modern surgical equipment, and a generous budget amply provides for the needs of a rapidly expanding health program. The Board of Supervisors in our smaller American communities consist of public-spirited men of great integrity of character, unselfish in their aims, devoted to the noble cause of public welfare, moved by deep sentiments of civic pride, and inspired by the highest ideals of continued progress in matters pertaining to the betterment of the social conditions of the indigent and helpless. On the other hand, the supervisors are bound by the force of economic circumstances to keep taxation within reasonable bounds and to place restraints on their generous impulses.

The smaller county hospitals need sympathetic interest and guidance rather than castigation or the whip of exclusion. The American College of Surgeons and other similar bodies of national standing should assume the burden of supervising and guiding the county hospitals in the interest of community welfare. If all these hospitals were approved, it would then be possible for every graduate from a medical school, upon completing his internship, to find a place in which he could continue general or specialized training. As nearly every county hospital has on its board practitioners of long experience, some of them outstanding in respective specialties, and others even fellows of the College of Surgeons, they could assume the burden of helping the young graduate worker to acquire greater efficiency in a chosen branch or specialty. Frequent leaves should also be granted for further training under university supervision.

Such a plan would provide advanced training for all graduates.

County Hospital.

William W. Richards,
Marysville.

SYNOVIAL POLYSACCHARID

According to Dr. Karl Meyer[1] and his colleagues of the Arthritis Clinic, Presbyterian Hospital, New York City, human synovial fluid contains a specific polysaccharid. chemically identical with the mucoid polylsaccharid elaborated by Group A Hemolytic streptococci. If this identity is confirmed, it would suggest a wholly new theory of arthritis and rheumatic fever and a newly plausible basis for therapeutic research.

Highly specific lipoids, polysaccharids and other chemical factors common to pathogenic microorganisms and animal tissues, have been a subject of research interest since Forssman[2] discovered the first heterophil lipoid of this type. This "Forssman lipoid" is found in certain strains of intestinal bacteria, and in conjugation with the tissue proteins of certain animal species. It is present, for example, in exceptionally high titer in guinea pig and horse tissues, but is absent from man and the rabbit. If a Forssman-positive vaccine is injected into a Forssman-negative animal (*e. g.,* a rabbit), a high-titer anti-Forssman antibody factor or function is formed. A Forssman-positive animal, however, is apparently incapable of forming these fractional antibodies, or, if formed, rapidly removes them from the circulation by conjugation with fixed tissue lipoids. An anti-Forssman serum injected into a Forssman-negative animal is nontoxic. Injected into a Forssman-positive animal, however, fulminating toxic symptoms may result. Thus, a Forssman-negative antiparatyphoid horse serum is nontoxic on intravenous injection into Forssman-positive guinea pigs. The homologous Forssman-positive rabbit antiserum, however, may cause lethal reactions.

The heterophil antigens of greatest current clinical interest, however, are certain lipoids and polysaccharids in type pneumococci. Since the same lipoids are normally present in horse tissues, an antipneumococcus horse serum is theoretically deficient in one antibody function essential for complete antipneumococcus humoral immunity. Theoretically at least, however, this handicap can be overcome by using rabbit antiserum. Of even greater practical interest is the heterophil carbohydrate, which is also present in human erythrocytes. Antipneumococcus horse serum, therefore, would theoretically be hemolytic or hemagglutinating for man.

Doctor Meyer's alleged identification of his synovial polysaccharid with the mucopolysaccharid of Hemolytic streptococci is based on chemical evidence. On acidulation, human synovial fluid yields about 225 milligrams of his polysaccharids per liter. Each molecule of this polysaccharid contains one equivalent of nitrogen, hexosamin, acetyl and hexuronic acid. It contains no sulfur or phosphorus. Identical fractional components in identical ratios were previously demonstrated by Meyer in polysaccharids isolated from vitreous humor and from the umbilical cord.[2] Almost identical qualitative and quantitative analyses have been reported by Kendall[3] and his coworkers for the mucopolysaccharid isolated from Hemolytic streptococci.

The apparent chemical identity of this streptopolysaccharid with synovial polysaccharid was confirmed by Meyer through a parallel study of their hydrolyses by the autolytic enzyme formed by type pneumococci. Within the limits of the experimental error this enzymic reaction was both qualitatively and quantitatively identical for both polysaccharids.

Since in their hands rabbits injected with heat-killed Hemolytic streptococcus did not yield precipitins or complement-deviating antibodies for the mucopolysaccharid, Kendall[3] and his coworkers concluded that the streptococcus mucopolysaccharid is "serologically inactive." The opposite conclusion is currently reported by Loewenthal[4] of London Hospital and Medical College, who found that by cautiously heating young mucoid phase streptococci (55 degrees, 12 minutes) so as to avoid denaturation, the streptomucopolysaccharid is antigenically active. Antigenic identity of the streptopolysaccharid and synovial polysaccharid, however, has not yet been confirmed by serologic evidence. Until this is done, an autocytotoxic theory of arthritis or rheumatic fever, a theory based on a presumptive immunological vicious circle, would be premature.

Box 51.

W. H. Manwaring,
Stanford University.

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[1] Meyer, Karl, Smyth, Elizabeth M., and Dawson, Martin, H.: Science, 88:129 (Aug. 5), 1938.

[2] Meyer, Karl, and Palmer, J. W.: J. Biol. Chem., 114:689, 1936.

[3] Kendall, F. E., Heidelberger, M., and Dawson, M. H.: *Ibid.,* 118:61, 1937.

[4] Loewenthal, H.: Brit. J. Exp. Path., 19:164 (April), 1935.

Adequate Medical Services Available in Texas County. —An abundance of free clinics, governmental hospitals and philanthropic organizations in Harris County, Texas, makes it possible for every one to obtain medical care, the County Medical Society reveals in a study of medical care during 1937. The survey, reported in *The Journal of the American Medical Association* for January 14, is part of a nation-wide study being sponsored by the Association.

An average of eighty-five patients for each of the 266 physicians included in the study received free treatment in homes, hospitals or doctors' offices during the year. The physicians also reported they had devoted 27,971 hours to free patients in clinics.

A majority of the people, including the low-income groups, could obtain and pay for necessary dental service when they made proper arrangements for obtaining such service. During 1937 the thirty-four dentists included in the survey provided 994 persons with free care in their offices and gave 960 hours of free service in clinics.

Not a single instance of refusal to hospitalize patients was recorded. Facilities for the care of school children were considered adequate.

A social service filter system to prevent persons who can afford to pay from obtaining care at the free clinics and to make fees for low-income groups commensurate with ability to pay was strongly recommended.

Other needs of the county as seen by the Society included additional funds to provide medical care for persons with infectious diseases, especially venereal diseases, and for those with chronic ilnesses who need institutionalized care, and provisions by relief agencies for care of transients and nonresidents who are ineligible for county aid.

ORIGINAL ARTICLES

TUBERCULOUS APPENDICITIS

By Thomas A. Card, M.D.
Riverside

Discussion *by Philip H. Pierson, M. D., San Francisco; Emile Holman, M. D., San Francisco.*

TUBERCULOUS appendicitis was first reported and described by Corbin[1] in 1937. In 1882 Koch[2] announced to the world the discovery of the bacillus of tuberculosis, and this stirred the medical profession to a more intense study of suspected lesions.

REPORTS IN THE LITERATURE

Until May, 1937, there have been in all 151 cases reported in the literature. That this condition is relatively rare is shown in a monograph by Mueller,[3] who published reports from various clinics showing autopsy findings. I am reporting only the larger clinics of his series. Fenwick and Dodwell, in 2,000 autopsies, had a percentage of 0.8; and Kelly, reporting 3,770 cases, had a percentage of 1.2. Koster and Kosman, 1934, collected a series of tabulations from clinics showing the percentage found at operation; and again I am reporting the larger clinics, as follows:

Clinic	*Year*	*No. of Cases*	*Percentage of Cases*
Mayo	1905	1,888	1.5%
Deaver	1902–13	7,610	0.2
Montreal General	1909	12,003	1.5
Mayo	1914	1,259	0.1
Free Hospital for Women, Brookline, Mass.	1902–1932	7,665	0.1
Koster	1928–1932	3,271	0.1

These series show the relatively close relationship in the findings of autopsy and operation.

It is generally believed by authorities that tuberculous infection of the appendix occurs either through direct extension or by the hematogenous route. The hematogenous route was favored by most authors where the pathology presented involved the appendix only. In view of the fact that the cecum and appendix quite frequently have decreased peristaltic activity and it is generally recognized that active tubercle bacilli are present free in the colon, is it not conceivable that organisms may, by direct peristaltic action, be carried into the lumen of the appendix from the cecum, and there by direct apposition infect the mucous membrane of the appendix? That is illustrated in Slide 6, where the only lesion found is in the submucosa of the wall.

RIVERSIDE COUNTY HOSPITAL PROCEDURES

The attention of the surgical staff of the Riverside County Hospital was directed from time to time to patients in the tuberculosis department who were complaining of abdominal distress with localization in the right lower quadrant. Many of the findings were rather vague and not typical clinically of the more acute and positive findings of those coming in the general surgery service.

Formerly we were apt to temporize with these cases, being reluctant to operate for fear of activating the pulmonary condition. It was our custom to treat them symptomatically by fluid diet, ice bag, and observation. Many of these cases quieted down, only to have a recurrence of symptoms from a few weeks to months later. Others would rapidly, and often without marked increase of symptoms, develop a palpable mass, and at operation we would evacuate an abscess or remove a greatly inflamed and distended appendix, with involvement in some cases of the cecum and surrounding viscera. Several of the cases developed fistula and chronic discharge, with rapid dissolution and death.

More recently, therefore, we have learned to give greater consideration to those tubercular patients complaining of such mild symptoms, and we have found that earlier operations have given a much higher percentage of cures with primary healing and without appreciable damage to the pathology in the lungs.

The choice of anesthetic in all of our cases was spinal, novocain 120 to 150 milligrams, or the combination of 50 milligrams novocain and 10 milligrams pantocain being used. This has proved satisfactory in our series, inasmuch as it has given adequate anesthesia, a convalescence with a minimum of nausea and no immediate irritation of the pulmonary condition. All of our cases have been transferred either to the tuberculosis wards or to their homes at the end of ten days. Healing in all of these cases was per primum. Postoperative care was routine, including adequate fluids by subcutaneous or intravenous method, until such time as fluids could be administered orally, usually within twelve hours.

Although the condition is relatively rare, it presents a problem which heretofore has seemingly been given little consideration; due, undoubtedly, to the fact that clinical symptoms are in most cases vague, and that proper evaluation of the pathology is difficult.

I wish to report eight cases occurring in a series of 520 appendectomies in the Riverside County Hospital between January, 1933, and February 1, 1938. These cases are proved tuberculosis of the appendix without demonstrated lesions found elsewhere in the intestinal tract. The percentage in this series is 1.5. All eight cases had proved pulmonary tuberculosis, most of them in the quiescent stage; and one, as the history will show, had been dismissed from institutional care as an arrested case and returned to the general hospital fifteen months later with a diagnosis of acute appendicitis.

The following cases are briefly summarized:

REPORT OF CASES

Case 1.—G. M. Hospital No. 17559. Male. Mexican. Age, 24.

Entered hospital on March 13, 1933, with positive pulmonary tuberculosis. On June 10, 1933, he complained of abdominal cramps and diarrhea. Eleven days later he had a recurrence of symptoms and localization of pain in the right side; temperature 100, white count 15,000, polymorphonuclear 76 per cent. On June 27, 1933, he again reported abdominal cramps. Examination showed tenderness and muscle spasm of the right rectus. Temperature not elevated, white blood count 8,750, polymorphonuclear 60 per cent.

Diagnosis: Chronic appendicitis; recurrent.

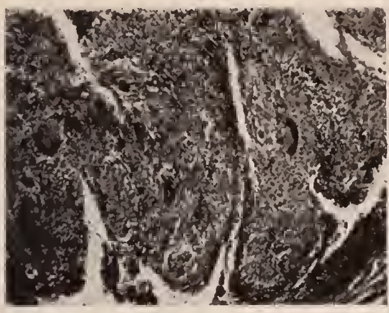

Fig. 1

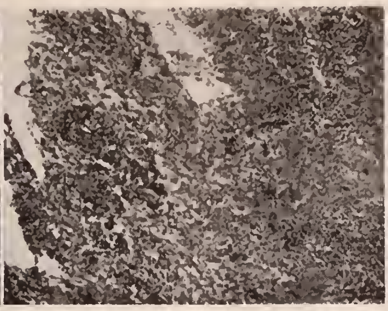

Fig. 2

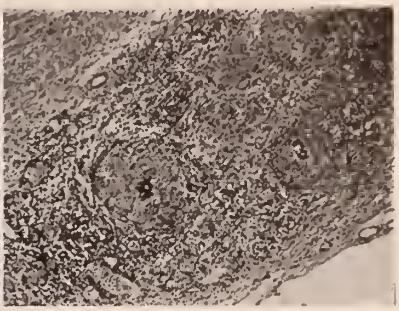

Fig. 3

Fig. 1 (Case 1).—Shows giant cells surrounded by tuberculous granular tissue.
Fig. 2 (Case 2).—Shows giant cells surrounded by tuberculous tissue.
Fig. 3 (Case 3).—Shows tubercles with a ring of inflammatory cells and giant cells, four in all.

Operation on same day, under spinal anesthesia. No evidence of visceral tuberculosis, no enlarged mesenteric lymph-nodes found. Cecum was normal in appearance, Appendix was free, involved in two definite kinks, giving a corkscrew appearance. Wall was injected and indurated.

Pathologic examination: The outer layers show perivascular, round-cell infiltration. In the lymphoid tissue there are a number of typical tubercles. The overlying mucosa in the section examined is not ulcerated. Diagnosis: Tuberculosis of the appendix.

* * *

Case 2.—C. Y. Hospital No. 20522. Female. Mexican. Age, 22.

Admitted to hospital in August, 1933, with diagnosis of pulmonary tuberculosis. She complained of rather severe pain in the right lower abdominal quadrant. Examination showed very slight tenderness over McBurney's area; no referred tenderness; no pelvic pathology. Temperature, 99.2; pulse, 90; white blood count, 11,500; polymorphonuclear, 76 per cent; urine negative.

Diagnosis: Acute appendicitis.

She was operated upon the same day, under spinal anesthesia. Appendix was distended in the terminal half and injected. There were a few grayish, white plaques over the serous coat of the appendix. There were no palpable glands at the base of the cecum.

Pathologic examination: The appendix measures 2 by 3 centimeters. The wall is greatly thickened on cut section. Microscopic examination: The mucosa is quite irregular; submucosa is infiltrated with numerous eosinophils. There is also much fibrous tissue present. There are areas revealing tubercles, consisting of giant cells and epithelial cells, surrounded by lymphocytes. Diagnosis: Tuberculosis of the appendix.

The patient made an uneventful recovery and had no further abdominal symptoms.

* * *

Case 3.—U. G. Hospital No. 21054. Female. Mexican. Age, 27.

Entered the hospital in April, 1934, with diagnosis of pulmonary tuberculosis. First complained of right-sided abdominal pain in July, 1934; temperature, 101; white blood count, 9,800; polymorphonuclear, 85 per cent. Ice bags were applied and condition quieted down. One month later the patient had a recurrence of abdominal pain, with elevation of temperature, and again ice bags were applied. Pain in the right lower quadrant persisted, and on palpation of the abdomen tenderness was noted over McBurney's area and in the pelvis. No muscle spasm was present. White blood count was 9,700; polymorphonuclear, 83 per cent. Abdominal symptoms continued and operation was done. Findings: Appendix retrocecal, six inches long, adherent, moderately injected, and edematous. There were a few small granular deposits on the serous coat of the appendix. The cemum showed no involvement and pelvic organs were apparently normal. No palpable glands were noted, appendix removed routinely without drainage.

Pathologic report: There is a deep constriction in the center of appendix. Serosa is congested. Lumen is distended by white purulent material. Microscopic: In places the mucosa and lymphoid tissue are greatly thinned apparently by pressure. There is some necrosis of the mucosa. There are many neutrophils and eosinophils in the inner layer. Much scarring of the submucosa and small groups of tubercles are present in the serosa. Diagnosis: Tuberculosis of the appendix and subacute purulent appendicitis.

The patient made a good postoperative recovery, with no further abdominal symptoms.

* * *

Case 4.—E. M. Hospital No. 21569. Male. Mexican. Age, 23.

Admitted to hospital on September 19, 1934, with a diagnosis of pulmonary tuberculosis. On February 24, 1935, he complained of pain and tenderness over McBurney's area. He reported a similar attack seven months before. Morning temperature was 98; evening temperature, 99.4; pulse, 90.

Examination, February 25, 1935, showed muscle spasm of right rectus, with localization of tenderness over McBurney's area. White blood count, 12,400; polymorphonuclear, 92 per cent. Diagnosis: Chronic appendicitis.

Operation: Some clear serum was found in abdominal cavity. Appendix was found clubbed at terminal portion,

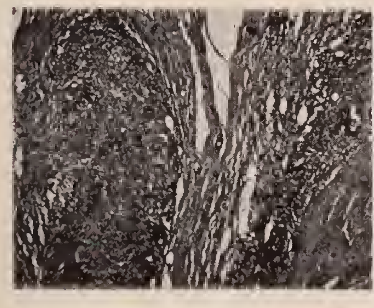

Fig. 4

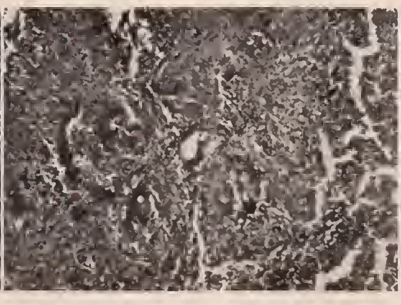

Fig. 5

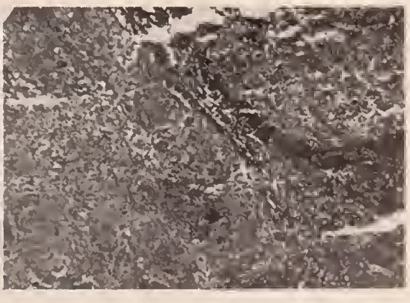

Fig. 6

Fig. 4 (Case 4).—Large tubercles with a great amount of caseous matter and giant cells.
Fig. 5 (Case 5).—Four tubercles with giant cells in central part of slide.
Fig. 6 (Case 6).—Shows definite tubercle formation with giant cells.

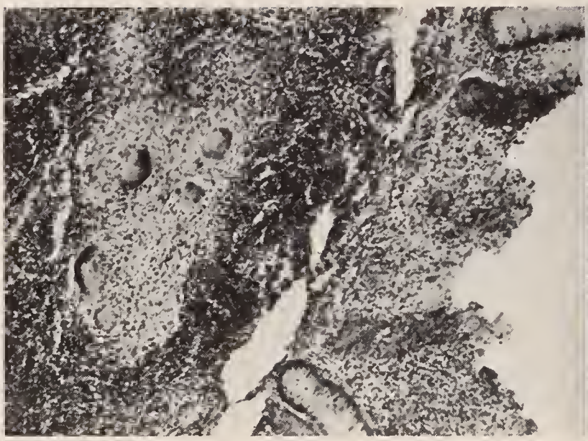

Fig. 7

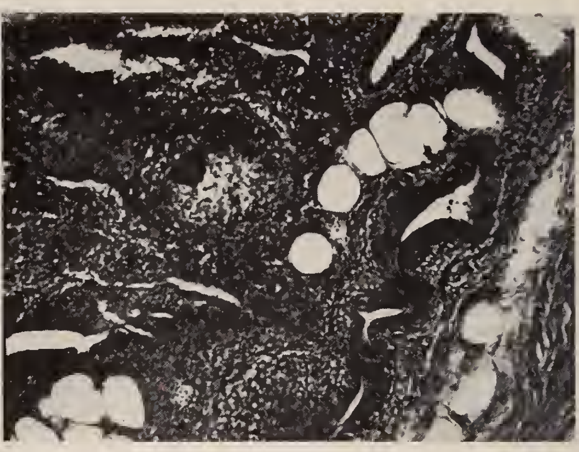

Fig. 8

Fig. 7 (Case 7).—Shows mucous membrane crypts. Large tubercles in lymphoid tissue with five giant cells.
Fig. 8 (Case 8).—Shows large tubercle with giant cells.

injected and indurated. There were a few pearl-like bodies in the serosa of the appendix. Cecum was not involved in inflammatory condition, no palpable glands noted.

Pathologic report: Gross appendix, 4.5 centimeters long; serosa is roughened, apparently by adhesions. Microscopic: At the distal end of the appendix there is a large caseous area, surrounded by a thin fibrous capsule. Tubercles are found in the mucosa and submucosa of the appendix. The lumen of the appendix and the mucosa contain some purulent exudate. Diagnosis: Tuberculosis of the appendix.

Postoperative course was uneventful, with primary healing. No further abdominal symptoms.

* * *

Case 5.—T. L. Hospital No. 33158. Female. Mexican. Age, 17.

Admitted to the hospital on July 28, 1938, with a diagnosis of pulmonary tuberculosis. On April 8, 1937, she complained of severe pain in the right lower quadrant of the abdomen. There were no positive abdominal findings. Temperature was 98; pulse, 80; white blood count, 12,900; polymorphonuclear, 76 per cent. On May 7, 1937, she complained of pain in right lower quadrant for one day only. There was no further abdominal distress until February 8, 1938, at which time she complained of pain in the right lower quadrant, no rigidity found. There was some tenderness over McBurney's area, with no rise in temperature, no nausea or vomiting. White blood count was 12,000, polymorphonuclear, 60 per cent; lymphocytes, 31 per cent. Five days later she still had pain; there was slight rectus rigidity with referred tenderness, no temperature elevation. White blood count was found to be 19,000. Preoperative diagnosis was probable tuberculous appendicitis.

Operation, February 14, 1938. Appendix was slightly elongated and distended, moderately injected. Cecum and adjacent small bowel were carefully inspected, but no pathology was found. Mesenteric lymph-nodes were not enlarged.

Pathologic report: Gross specimen is an appendix measuring 8 by 1.3 centimeters, with much adherent fat. The serosa is thickened. The wall is up to 4 millimeters thick. The lumen contains coagulated white material. Microscopic: The subserosa is infiltrated by many round cells and plasma cells. The muscularis contains many such cells and is edematous. The lymphoid tissue contains many tubercles. Diagnosis: Tuberculous appendicitis.

The patient made an uneventful recovery.

* * *

Case 6.—R. C. Hospital No. 36993. Female. Mexican. Age, 16.

Admitted to hospital on August 5, 1937, with a diagnosis of pulmonary tuberculosis. On January 29, 1938, she first complained of slight pain in the right lower quadrant. On February 4 she again complained of pain in her right side. No rigidity of the right rectus, but there was some tenderness on deep pressure over McBurney's area. White blood count, 19,200; polymorphonuclear, 85 per cent; temperature, 98. The next day the white blood count was 18,400. Because of the clinical evidence, a diagnosis of tuberculous appendicitis was made and she was operated.

Findings: Appendix located normally, somewhat twisted on itself, with many adhesions between the meso-appendix and the cecum. Examination of the adjacent organs was entirely negative for any other pathology.

Pathologic report: Microscopic, the appendix appears quite normal, except for a collection of small epithelial tubercles in the submucous lymphoid tissue. Some of these contain Langhans' giant cells. Diagnosis: Tuberculosis of the appendix.

The patient made an uneventful recovery.

* * *

Case 7.—A. S. Hospital No. 37247. Female. Mexican. Age, 17.

Entered the hospital with a diagnosis of pulmonary tuberculosis on August 31, 1937. On September 29, 1937, she complained of nausea, later associated with vomiting, but no abdominal pain. On January 23, 1938, she complained of pain and tenderness in the right lower quadrant. Temperature was not elevated, pulse 100. White blood count 16,000, with polymorphonuclear count of 67 per cent. Examination showed no spasticity or evidence of muscle rigidity. Tenderness over this region was slight. Morning temperature 97.8, pulse 90. At this time the white count was 12,500, with 85 per cent polymorphonuclear.

On February 5 she had a pneumothorax of 300 cubic centimeters, with temperature of 99.2 following; pulse 110. At this time she complained of a recurrence of pain in the right lower quadrant. There was increased muscle spasm and definite localization of pathology. Preoperative diagnosis: Subacute appendicitis, with possible tuberculous appendix.

Operation: The cecum and appendix were found and removed from the abdomen. The tip of the appendix was markedly injected and slightly swollen. There were no enlarged mesenteric glands found and no tubercles on the cecum. The uterus, ovaries, and tubes were all found to be normal. The abdomen was closed in layers in the usual manner.

Pathologic report: Section from appendix shows definite group of tubercles in the lymphoid tissue at one side of the appendix. The tubercles have the appearance of having developed rather rapidly. Diagnosis: Tuberculosis of the appendix.

Patient made an uneventful recovery and had primary healing of the wound.

* * *

Case 8.—C. L. Hospital No. 31706. Female. Mexican. Age, 18.

Admitted to hospital on February 7, 1938, with a diagnosis of acute appendicitis. She had been a patient in the tuberculosis hospital from September 30, 1935, to July 10, 1937. Present symptoms were sudden onset of pain in right lower quadrant, slight at first but becoming more severe and frequent. White blood count on admission was 12,550, with 73 per cent polymorphonuclear, temperature 99, and pulse 100. The patient stated that she had had no previous attacks of similar abdominal pains.

She was operated the following day. There were numerous adhesions around the entire appendix, it being bound firmly to the cecum, moderately injected and somewhat swollen and indurated. There were several fine, white plaques on the appendix. The cecum adjacent to the appendix was injected moderately. No mesenteric glands found; ovaries, tubes, and uterus were normal to palpation.

Pathologic report, microscopic: All the coats are moderately infiltrated with round cells and a few polymorphonuclears and eosinophils. In the muscularis and mucosa are numerous tubercles. Diagnosis: Tuberculous appendicitis.

The patient made an uneventful recovery.

COMMENT

In reviewing these cases one notes that all have had tuberculosis of the lungs, that most of them were in a quiescent phase, that careful history revealed one or more previous attacks of low-grade abdominal pain, with localization in the right lower quadrant. White blood counts and temperature reactions have been, for the most part, little disturbed above normal, even in those cases that gave rather pronounced clinical findings. All have shown gross pathological changes and all have had tubercles present in various layers of the appendix. Operation in these cases have all been satisfactory, as noted by the prompt healing, and convalescence and absence of further abdominal distress.

Death from advanced pulmonary tuberculosis in the first four cases cannot, we think, be directly attributable to the operations, inasmuch as there were no exacerbations of the pulmonary lesions immediately after operation, and death occurred many months later. In our later cases we attached greater significance to mild, right side, localized tenderness, and suspecting tuberculosis of the appendix we operated early.

I believe this procedure, as outlined, will lessen the danger of later extensive appendiceal abscess formation and cecal involvement. Tuberculous appendicitis occurring secondary to infection elsewhere in the body would seem, in our experience, to be less rare than the literature suggests; and the medical profession, particularly those in charge of our tuberculosis hospitals, should keep in mind this complication and be on the alert to seek early surgical care.

Pathological reports were made through the pathological laboratory of the School of Medical Evangelists, Loma Linda, Dr. Oran I. Cutler, Chief.

SUMMARY

1. Tuberculous appendicitis is reported 151 times in the literature to May, 1937, and eight more cases are added in this report.

2. Clinical course of the disease tends to chronicity, with recurrent attacks usually milder than the pyogenic types of appendicitis.

3. Eight cases are briefly summarized and microscopic sections shown of the involved appendix.

4. Earlier recognition by the physician should be made.

5. Early operation, with removal of involved appendix, will reduce the morbidity and mortality in our tuberculosis sanitaria.

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DISCUSSION

Philip H. Pierson, M. D. (490 Post Street, San Francisco).—The subject presented by Doctor Card is very timely. Many patients with pulmonary tuberculosis have tuberculosis of the intestine which may give no clinical symptoms, yet be present on x-ray examination. It is interesting, in view of the frequency of tuberculous enteritis chiefly located in the ileocecal region, that tuberculous appendicitis is so relatively rare. Doctor Card's cases surprised me somewhat in that there was so little involvement of the ileocolic glands. Very frequently tuberculosis in these glands, with no involvement of the appendix, causes all the symptoms of tuberculous appendicitis.

I agree with Doctor Card perfectly in regard to the surgical treatment of this condition. Localized ulcerative lesions in the ileocecal region very frequently respond to ultra-violet irradiation with a complete cure.

I think that it is wise at this time to stress the value of the x-ray in diagnosing these lesions. By early recognition and treatment the patient's pulmonary condition improves much more rapidly. We have recently seen, at Stanford Hospital, a patient with coccidioides of the appendix. As the symptomatology and pathology are so similar to that of tuberculosis this should be kept in mind, particularly in those regions where coccidioides is prevalent.

⁂

Emile Holman, M. D. (Stanford University Hospital, San Francisco).—Tuberculosis of the appendix is not unexpected in the presence of symptoms referable to the right lower quadrant appearing in a patient harboring also a known pulmonary tuberculosis. Its occurrence, however, as the only known tuberculous lesion is most uncommon, but apparently does occur. In a patient upon whom we were about to perform a cholecystectomy for gallstones, I once delivered an indurated, obviously diseased appendix, which, so far as anyone knew, had not been responsible for the patient's symptoms. Microscopically, the appendix showed typically tuberculous lesions. No other focus of tuberculosis could be demonstrated, either in the abdomen or in the lungs.

In California there exists another lesion of the appendix which is easily mistaken for tuberculosis. A young Filipino, who had resided for a short time in the San Joaquin Valley, was recently operated upon for rather severe lower right quadrant symptoms which seemed easily explained, at operation, upon the basis of tuberculosis. Numerous tubercles studded the peritoneum overlying the cecum and the parietal peritoneum around the appendix, which was indurated and inflamed and, therefore, removed. The pathologist's first report confirmed the operator's impression that the lesion was tuberculous. Further study, however, revealed the typical spheroid bodies of coccidiodes.

Doctor Card is to be congratulated upon the primary healing that occurred in these eight tuberculous lesions of the appendix. His admonition to operate when right lower quadrant symptoms first arise, is, I believe, well warranted, in the hope that the lesion may still be limited to the appendix. Fistulae, localized peritonitis, and subsequent intestinal obstruction occasionally complicate the removal of the more advanced lesions seemingly limited to the appendix, but probably already involving the cecum. It is possible that the early removal of the tuberculous appendix will prevent the subsequent extension of the tuberculous process to the cecum.

TRAUMATIC DIAPHRAGMATIC HERNIA: TRANSPLEURAL REPAIR*

By H. E. Schiffbauer, M.D.
Los Angeles

Discussion *by Charles Eaton Phillips, M. D., Los Angeles; Emile Holman, M. D., San Francisco.*

In this paper I shall discuss and report eight cases † of traumatic diaphragmatic hernia which I have operated upon since October, 1935, by the transpleural approach, with recovery.

Diaphragmatic hernia can be divided into two groups: (1) nontraumatic; (2) traumatic. The nontraumatic are subdivided into congenital and acquired. Hedblom, in an analysis of 378 operated cases, found that two-thirds were of traumatic origin; one-sixth congenital and one-sixth acquired.

With the increase of injuries resulting from automobile accidents, the incidence of traumatic rupture of the diaphragm has increased.

TRAUMATIC HERNIA

Traumatic hernia may result from direct or indirect injury. Direct injuries to the diaphragm resulting from penetrating wounds, such as stab or gunshot, impalements and punctures from fractured ribs, are often accompanied by injuries to the lungs, liver, stomach, spleen, and kidneys.

Instances are reported of the rupture of the diaphragm during labor, vomiting, heavy lifting, and having the lower chest and upper abdomen crushed while wrestling. Rupture of the diaphragm has occurred in divers jumping from great heights and landing on their abdomen, also in persons jumping from a window and landing on their feet.

Rupture of the diaphragm has resulted from severe crushing injuries to the chest, with or without fractures. Fractures of the transverse processes of the upper lumbar vertebrae may also be a contributing factor.

Weakening of the diaphragm has resulted from a stiff rubber tube improperly placed in draining an empyema, causing an erosion of the diaphragm and a weakness of the muscle. With a sudden increase in the intrathoracic pressure, a tear occurs and a hernia develops.

A complete repair of the tear in the diaphragm will take place, provided no viscus intervenes between the edges of the torn muscle.

It was noted in the eight cases that the tear was parallel to the muscle fibers, extending from the anterolateral attachment of the diaphragm to the region of the esophageal hiatus. It is quite possible that the tear began at the central tendon in the dome of the diaphragm and extended anteriorly and posteriorly.

PATHOLOGY

No hernial sac was found in any of the eight cases. The formation of a sac depends upon the size and location of the defect in the diaphragm, and the rapidity with which the abdominal viscera enter through the defect. It is not infrequently seen in puncture wounds of the diaphragm, which develop a herniation into the pleural cavity years after the injury.

When a defect in the diaphragm exists, the intra-abdominal pressure associated with the continuous suction action of the diaphragm gradually increases the amount of the abdominal viscera in the chest. The viscera found in the pleural cavity depends upon the size and location of the tear in the diaphragm, and the rapidity with which the viscera enters immediately after injury.

In none of the cases was there any fluid, or bloodclots in the pleural cavity, and no adhesion between the lung and abdominal viscera. In two cases the lower lobe of the lung was adherent to the anterolateral chest wall by a cord-like bands. In all cases the lower lobe was more or less atelectatic; in one case the upper lobe was also partially airless. The lung was completely reëxpanded in all cases, without any ill effects from the reëxpansion.

SYMPTOMS

A paucity of clearly defined symptoms referable to the thorax and abdomen is characteristic in traumatic rupture of the diaphragm.

It is necessary to consider the symptoms arising from the acute and chronic case, and the chronic case which has become acute.

Acute Cases:

When the patient has been severely injured, there are many symptoms and conditions which make it comparatively easy to overlook a tear in the diaphragm, especially when it has been effectively plugged by the stomach, and on examination of the thorax the characteristic signs are absent or difficult to recognize.

It is then important to decide if a perforation of the abdominal viscera, an acute hemorrhage or an incarceration of the intestine exists, with a rupture of the diaphragm.

Chronic Cases:

Atypical and vague gastro-intestinal symptoms in the left hypochondrium, often associated with indefinite pleuritic pain, and a history of injury to the upper abdomen and lower chest, should demand a critical study by a roentgenologist.

Peritoneoscopic examination might be considered in making a diagnosis in obscure chronic cases with indefinite thoracic and abdominal symptoms.

Chronic Cases Which Have Become Acute:

The most common symptom is the sudden onset of severe colicky pain in the hypochondriac region, which is often referred to the neck, shoulder region and anterior lower chest, followed by nausea and persistent vomiting with a disturbance of bowel movements.

The characteristic symptoms of abdominal viscera in the pleural cavity may be absent.

A flat plate of the abdomen and lower chest will often aid in making a diagnosis of incarceration of intestinal viscera in a tear of the diaphragm.

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* Read before the General Surgery Section of the California Medical Association at the sixty-seventh annual session, Pasadena, May 9–12, 1938.

† Only two case reports appear in this issue. Others will be given in the reprints.

PHYSICAL FINDINGS OF THE CHEST

Inspection:

There may be no laceration, contusion, subcutaneous emphysema or evidence of injury to the chest wall or upper abdomen.

The prominence of the chest findings depends upon the kind, amount, distribution and detention of the abdominal viscera, and the rapidity with which they entered the pleural cavity after the tear in the diaphragm, and if a complete pneumothorax resulting from the injury to the lung exists.

Therefore, it is obvious that in some patients dyspnea and cyanosis, with shallow respiration and a lagging of one side of the chest, are the outstanding symptoms, while in others these are absent.

A bulging of the hypochondriac region may be present.

The abdomen is usually scaphoid and often less prominent.

Palpation:

Subcutaneous emphysema, a hematoma and crepitation over the fractured ribs may be elicited. The apex of the heart is usually displaced to the right. Abnormal fremitus is often present. The abdominal muscles are usually rigid.

Percussion:

Normal resonance is displaced by tympany over the anterior chest and the degree of dulness, posteriorly, depends upon the amount of fluid present and the extent of atelectasis.

The tympanic sounds may be caused by a pneumothorax, and cannot be differentiated by percussion from abdominal viscera in the pleural cavity.

Auscultation:

The heart sounds are distant and displaced to the right. Normal breath sounds are decreased or absent, depending upon the amount and distention of the abdominal viscera in the pleural cavity and the presence of a pneumothorax.

Hearing peristaltic contraction over the chest is pathognomonic of intestinal organs in the pleural cavity. The shifting of the patient and listening for many minutes may be necessary before peristalsis is heard.

Gurgling is readily demonstrated over the anterior chest, in the fourth or fifth interspace, by having the patient take liquids in a sitting position.

This auscultatory finding can be accentuated by the administration of an effervescent powder. The application of the powder may be of value during a fluoroscopic examination when a pneumothorax exists, with a ruptured diaphragm.

Any gurgling, splashing or rumbling sound in the chest should be carefully investigated.

The routine fluoroscopic and x-ray examination will often fail to detect a rupture of the diaphragm.

DIAGNOSIS

Kirkin [1] states that the chief obstacle to the diagnosis of a diaphragmatic hernia is the neglect to look for it.

It is often extremely difficult to make an early diagnosis of traumatic diaphragmatic hernia because of the severe concomitant injuries and the bizarre, vague chest and abdominal symptoms. It is my impression that in many cases when the tear in the diaphragm is small, the fundus of the stomach plugs the opening immediately after the injury and prevents the early thoracic symptoms. Later the stomach, along with other movable viscera, may be drawn into the chest, producing the characteristic thoracic symptoms.

A critical study of all such injured persons should be made.

TREATMENT

Keen and experienced judgment is required to decide whether or not to operate upon an acute diaphragmatic rupture when a diagnosis has been made shortly after the injury. In serious injuries to the abdomen, a perforation of the hollow viscus, hemorrhage or incarceration, must always be considered. After observation over a period of hours, if the clinical picture suggests a possibility of any serious intra-abdominal lesion, an exploratory laparotomy should be done. If the patient is in an extremely serious condition, it might be advisable only to control the hemorrhage, repair the perforated viscus or relieve the incarceration, but not repair the rent in the diaphragm. The additional surgery may be too much for the patient to tolerate, but he can survive with a tear in his diaphragm, which can be repaired at a later date.

If intra-abdominal injury can be excluded, it is advisable to institute conservative treatment until such time as the patient is a good operative risk. However, the earlier surgery can be done the less difficulty will be encountered. Chronic cases which become acute should be operated upon at once, by the abdominal route. A supraclavicular temporary phrenic interruption is optional immediately before the laparotomy; nasal gastric lavage should always be done prior to surgery, leaving the tube in the stomach during and after surgery.

In chronic cases, transpleural approach offers many advantages over the abdominal route:

1. Adequate exposure is readily obtained.
2. The phrenic nerve may be crushed or injected with novocain as it enters the diaphragm, which insures an early return of function. After the hernial opening is exposed, it may not be advisable to interrupt the phrenic nerve, where in the abdominal method this must be done before surgery. This is an advantage.
3. Adhesions of the abdominal viscera to the lung or chest wall can be severed by sharp dissection under direct vision.
4. The atelectatic lung can be properly reexpanded by positive pressure under direct vision.
5. If necessary, a fascia lata transplant with living fascial sutures can easily be done, with a decrease in circumference of the chest by multiple rib resection, if necessary.

When difficulty is encountered, by either the abdominal or transpleural approach, it is advisable to combine both methods. The operator should be familiar with each method, and the anesthetist capable of giving positive pressure anesthesia.

PREOPERATIVE TREATMENT IN CHRONIC CASES

In the chronic case it is advisable to give the patient a nonresidual diet of high caloric value, with an adequate amount of liquids for the dehydrated patient.

A blood transfusion should be given when the patient is anemic or has a low blood pressure. The evening before the operation a thorough gastric lavage should be done, to be repeated before going to surgery, leaving the intranasal Levine tube in the stomach. When a distended transverse colon is in the pleural cavity, a high rectal tube should be inserted.

ANESTHETIC

Avertin, 70 to 90 minims per kilo body weight, supplemented with nitrous oxid and oxygen, under 10 to 14 millimeters of mercury with positive pressure, was satisfactorily used in three cases. In one case—that of a twelve-year-old boy—only nitrous oxid was used, with good results. In one case it was thought advisable to use ethylene. In three cases, cyclopropane, given by the intratracheal method, was used to an advantage. The operative procedure is made less difficult with this type of an anesthetic.

I have come to the conclusion, in reference to anesthesia, that the most important factor is not the kind of anesthetic agent and mode of administration, but the anesthetist giving the anesthetic.

TECHNIQUE OF THE TRANSPLEURAL OPERATION

The patient is placed on the operating table on his good side, resting on a sand bag or folded blanket under the midaxillary portion of his chest.

The incision begins just lateral to the costal attachment of the ribs in the eighth interspace, and continues backward, parallel to the ribs to their angles. The pleural cavity is opened the entire length of the incision.

Upon opening the pleural cavity, in chronic cases, few changes take place in the patient's general condition because the mediastinum has been stabilized and the structures have compensated for the altered conditions within the affected pleural cavity.

To enlarge the opening in the pleural cavity, the eighth and ninth ribs are cut between two punched holes about two centimeters apart, just lateral to the angle of the ribs. After protecting the wound edges with gauze pads, self-retaining retractors are inserted at the upper and lower angles of the incision, and the wound is widely separated.

If, on exploration, the colon is markedly dilated and more than the usual amount of difficulty is encountered in deflating the colon, the possibility of a growth in the distal portion of the colon should be considered; and, if found, a cecostomy with immediate decompression technique is advisable.

The stomach should be examined for pyloric stenosis, ulcer, malignancy, and a volvulus. I failed to recognize the volvulus in the first case, necessitating an abdominal operation for its correction. This condition could have been easily repaired at the first operation, if it had been recognized.

The phrenic nerve is readily seen at its entrance into the diaphragm and easily crushed with a forceps, producing a temporary paralysis of the diaphragm, which facilitates the reduction of the abdominal viscera and the repair of the hernial opening.

The phrenic interruption may not be necessary in all cases. The adherent abdominal viscera are separated from their attachment to the lung and inner chest wall by sharp dissection. Structures are always adherent to the margins of the hernial opening; these are loosened, and if necessary the opening in the diaphragm enlarged, which makes the reduction of the abdominal viscera easier and allows for an exploration below the diaphragm, which should be done in all cases.

After the edges of the diaphragm have been denuded, they are approximated, without tension, with interrupted black silk sutures. If the defect in the diaphragm cannot be closed without tension, a fascia lata transplant, using fascial sutures, can readily be used to fill the defect.

In the eight cases it was interesting to note the gradual expansion of the atelectatic lung after the abdominal viscera had been replaced. In the one case where the accident had occurred ten years previously, the atelectatic lung was gradually but completely reëxpanded by an increase of positive pressure through the tracheal catheter.

Before closure of the pleural cavity the sectioned ribs are approximated with kangaroo tendon. The opening in the pleural cavity is closed by placing interrupted No. 1 chromic sutures around the ribs, above and below the intercostal opening. The muscles and fascia are approximated in their anatomical planes with No. 1 chromic sutures. The pleural cavity is not drained.

POSTOPERATIVE TREATMENT

No unusual postoperative treatment is necessary, excepting that the intranasal Levine tube should be left in the stomach and connected with a constant suction apparatus for forty-eight to seventy-two hours, to prevent a gastric dilatation.

If only a small amount of fluid collects in the pleural cavity, it should not be aspirated.

CONCLUSIONS

Eight cases of traumatic diaphragmatic hernia have been reported, seven males and one female, ranging in age from twelve to fifty-seven years, in which four early and four late diagnoses were made, varying from a few months to ten years.

Earlier diagnoses will be made when the physicians become familiar with the symptoms resulting from a diaphragmatic hernia, and the roentgenologist makes a critical study of cases receiving direct and indirect injuries to the lower chest and upper abdomen, where vague and not clearly explainable thoracic and abdominal symptoms exist.

The earlier the patient can be operated, consistent with safety, the better.

If it is necessary to explore the abdomen shortly after an injury, and a diaphragmatic tear is found but effectively plugged by the stomach, it is advisable to do the urgent surgery and leave the repair of the diaphragm for a second operation.

The transpleural repair after a temporary phrenic interruption, using intratracheal cyclopropane anesthesia under positive pressure, is the method of choice in operating upon the chronic case of traumatic rupture of the diaphragm.

REPORT OF CASES

Case 1.—Mexican, age 30, injured in an automobile accident on May 10, 1935. Admitted to hospital in a comatose condition, suffering from cerebral concussion, acute alcoholism, and left lower chest injury.

Roentgenograms on May 11 revealed a fracture of the tenth and eleventh ribs posteriorly, without material displacement. No unusual findings in the chest. A small comminuted fracture of the left iliac bone was noted. The patient was discharged from the hospital on May 18, 1935. Because of gastro-intestinal symptoms which were present since the accident, he was given an appointment in the medical out-patient clinc.

He reported to the clinic on May 22, 1935, complaining of diffuse epigastric colicky pain, dyspnea upon exertion, and a nonproductive cough. These symptoms had developed since the accident. A hyper-resonance with decreased breath sounds, and a few crepitant râles at the apex were noted, and a tentative diagnosis of pulmonary tuberculosis was made.

Roentgenograms on May 23 showed a partial pneumothorax, involving the lower left lobe of the lung with a fluid level extending to the sixth interspace anteriorly.

On June 22, 1935, on fluoroscopic examination it was noted that the fluid had disappeared and a high, not well-defined diaphragm, with a deformity of the left dome, aroused suspicion, and upon the administration of barium, the cardiac end of the stomach was seen at the level of the seventh rib posteriorly. A diagnosis by the roentgenologist, of traumatic rupture of the diaphragm, was suggested. On September 15, 1935, he was readmitted to the hospital, complaining of distress in the epigastrium, nausea after eating, and dyspnea upon exertion, since the accident in May, 1935. The barium meal and barium enema revealed that the stomach and colon were in the left chest. A transpleural approach was made through the eighth interspace, under ethylene anesthesia and positive pressure. The entire stomach, transverse colon, spleen, and a portion of the small intestine were in the left pleural cavity. The lower lobe of the lung was atelectatic.

The rent in the diaphragm was about 16 centimeters long, extending obliquely backward from the anterolateral attachment of the diaphragm over its dome to the esophageal hiatus. After crushing the phrenic nerve the viscera were dissected from the margins of the tear in the diaphragm and the abdominal structures replaced into the abdomen and the rent repaired with interrupted silk sutures.

The intercostal wound was closed by placing chromic sutures around the rib above and below the incision, with a continuous chromic suture for the muscle and fascia. Convalescence was delayed by wound infection and a small empyema which healed after adequate drainage was established.

Three months after surgery the patient complained of epigastric distress after meals. He stated that he felt a fullness under his left ribs after eating and that, by bending over and massaging the upper left abdomen, he could feel the food pass into the lower portion of the stomach.

Roentgenological examination with a barium meal revealed a ruminating type of stomach. His condition did not improve with medication and dietetic management. The abdomen was opened through a left rectus incision. A short dense band of adhesions was found, extending from the greater curvature of the stomach at its upper third, to the posterior portion of the scar in the diaphragm, rotating the upper portion of the stomach on itself. After severing this band the stomach assumed a normal position. The previous rent in the diaphragm was visible and firmly healed. Upon subsequent examination the patient was in excellent health and free of complaints.

The second operation could have been obviated if a more thorough examination had been made during the first operation.

* * *

Case 2.—Male, age 30. On October 19, 1931, was in an automobile accident, receiving injuries to the head, left chest, and lower back.

Roentgenograms on October 20, 1931, disclosed a fracture of the seventh rib in midaxillary line, with no material displacement; a fracture of the superior and inferior rami of the left pubic bone; fracture of the left acetabulum, with some inward displacement; fracture of the first and second sacral segment on the left side. No abnormal findings in the chest. Discharged from hospital on December 29, 1931.

At intervals, from January 7 to October 27, 1932, the patient was seen in the orthopedic clinic. No reference to chest.

In April, 1935, he fell off the running board of a car, striking his head. He was dizzy, with blurred vision and headaches. Diagnosis: Concussion. X-ray examination showed no skull fracture.

On October, 1935, chest was examined; impaired resonance in left apex with fine râles present. Diagnosis was made of pulmonary tuberculosis early, and he was sent to the tuberculosis clinic.

X-ray of October 3, 1935, showed hydropneumothorax, with fluid level at eighth interspace near posterior axillary line. Slight collapse of left lung; evidence of thickened pleura in interlobar fissure.

On July 29, 1936, x-ray showed diaphragm level third interspace, anterior. Stomach lies immediately under diaphragm medially and anteriorly. Diaphragm is terraced from anterior to posterior, so that it is at eighth rib anterior. There are loops of small intestine laterally and posteriorly to the stomach and beneath the diaphragm. The barium entered the stomach readily and emptied into the duodenum normally. The left diaphragm was slightly movable. The findings were consistent with those of a diaphragmatic hernia.

On August 5, 1936, the patient was operated upon by the transpleural approach. On opening the pleural cavity the entire stomach, transverse colon, about 20 centimeters of small intestine, and the spleen were in the pleural cavity. The lower lobe of the lung was atelectatic.

The tear in the diaphragm began at its anterolateral attachment and extended backward toward the esophageal hiatus. The tear was repaired with interrupted silk after the abdominal viscera were replaced into the abdomen.

A pleural effusion occurred postoperatively, and was gradually absorbed without any complications.

On October 13, 1936, the x-ray showed the stomach in normal position, below the diaphragm.

1005 Brockman Building.

REFERENCE

1. Kirklin: J. A. M. A. (Dec. 27), 1930.

DISCUSSION

Charles Eaton Phillips, M. D. (2007 Wilshire Boulevard, Los Angeles).—Doctor Schiffbauer has given us a comprehensive treatise on the transthoracic repair of diaphragmatic hernia. But there are a few points in the surgical treatment of diaphragmatic hernia which should be accentuated.

First: The diagnosis of diaphragmatic hernia may offer many difficulties. A majority of the cases are not recognized until the condition has become well developed. Many are not found or even suspected until they are found at autopsy. Diaphragmatic hernia, like others, develop in points of congenital weakness, except those which follow direct traumatism such as from drainage tubes, wounds of the diaphragm, etc. A great majority are well developed when some sudden strain brings on an acute exaccerbation, and this leads to their discovery.

Even the exploratory operation may fail to reveal its presence unless there is x-ray evidence to guide the examination.

The mere presence of a diaphragmatic hernia is consistent with a normal span of life and activity.

It becomes a surgical emergency only in the rare cases where it is complicated by acute displacement of the stomach or other viscera, and possible strangulation.

The surgical relief of the condition has had the advocates who favored the abdominal, and others who have preferred the transthoracic approach. Each has had its technical difficulties and its advantages. Both approaches are formidable procedures which require skill and special instruments in their performance.

For the past ten years I have employed an approach which has presented certain advantages over either the classic thoracic or abdominal incisions.

Operation: A left paramedian incision is made, severing the seventh costal cartilage and extending downward to the level of the umbilicus. A careful exploratory is then performed. From the upper end of this incision the opening is continued outward and downward along the attachment of the diaphragm for a distance of eight inches. This flap is then turned outward and downward, leaving a triangular opening with the diaphragm edge presenting. It gives ready access to both sides of the diaphragm and at the same time perfect exposure to the structures, such as the splenic pedicle and vessels which may be injured in either of the other approaches.

Separation of adherent viscera and ligation of all bleeding points, and replacement of viscera, can be accomplished with certainty. Closure of the defect is simple and is usually accomplished with two or three rows of a forty-day chromic gut.

After the diaphragm has been repaired the costochondral flap is replaced and the cut edge of the diaphragm is included in the running chromic stitch which closes the lateral prolongation of the incision.

The paramedian incision is then closed in the same manner, completing the operation. Even in difficult cases the time of operation should not take more than thirty minutes. No subsequent trouble has been encountered with the fracture of the costochondral flap. No special instruments are necessary.

In the presence of adherent viscera it furnishes the ideal approach.

Many cases are not surgical. Surgery may be contraindicated by age, physical condition, or personal preference. In these, great relief may sometimes be obtained by increasing the intrathoracic pressure. These patients may develop a certain emphysema by blowing rubber balloons two or three times a day. The improvement, following this simple procedure, has been startling in some cases.

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Emile Holman, M. D. (Stanford University Hospital, San Francisco).—Doctor Schiffbauer has very ably and very completely covered the subject of diaphragmatic hernia due to trauma. Physicians generally, and industrial and traumatic surgeons in particular, will do well to bear in mind the possibility of such a hernia incident to any severe trauma to abdomen or to chest. If a diagnosis of hernia through the diaphragm is made, and if abdominal symptoms predominate, the abdominal approach is indicated, preferably through a long incision parallel to the costal margin extending through the linea alba medially and to the anterior axillary line laterally. An excellent exposure of the diaphragm is obtained, and after reduction of the hernial mass it is sometimes possible to identify and crush the phrenic nerve through the rent, if this is deemed necessary to approximate the edges of the rent.

Occasionally, in the abdominal approach, it is difficult to withdraw the abdominal viscera through the rent because of the negative pressure in the thoracic cavity. This can be simply overcome by the passage of a small catheter through the rent alongside the herniated mass, and by the introduction through it of air into the thoracic cavity above the diaphragm, thus equalizing the pressures in the two cavities.

VITAMIN-DEFICIENCY STATES: THEIR RECOGNITION AND TREATMENT*

By Dwight L. Wilbur, M.D.
San Francisco

PART I

The concept that disease may be due to deficiency of vitamins has received such widespread proof, and has been so universally accepted, that our clinical interest must now turn to means of recognizing and treating vitamin-deficiency states as well as to a study of the events leading to development of them. The importance of establishing these points lies principally in the fact that vitamin-deficiency states are an unusual group of diseases in that they can be entirely prevented and that, with the exception of a few extreme instances, they are completely amenable to cure.

CHARACTER OF DEFICIENCY STATES

For purposes of a clearer understanding of deficiency diseases and the difficulties surrounding recognition of them, such a simple grouping as that presented in Table 1 is of considerable value. In the first group are those patients who, with a marked degree of deficiency, present a classical deficiency disease, as xerophthalmia, beriberi, or pellagra. Such a condition depends on definite pathologic changes in the tissues, it can be recognized by clinical means without recourse to special tests, and it is infrequently encountered in this country.

In a second group may be placed those diseases which are usually due to a moderate degree of deficiency, such as the multiple neuritis of chronic alcoholism, nutritional night blindness, certain types of macrocytic anemia and glossitis. In these cases the deficiency is less marked than in the cases of the preceding group, the symptoms depend on physiologic and pathologic changes, and the diagnosis may rely on the use of special diagnostic tests.

In many respects the sequence of events in these two groups of "deficiency states" may be likened to those occurring in patients with diabetes, nephritis or cardiac disease. Patients with a marked degree of vitamin deficiency may be said to be analogous to diabetic or nephritic patients who are in coma, or to cardiac patients who are decompensated and in whom the pathologic changes are extensive and the diagnosis may be made by clinical means alone. Patients with less marked degrees of deficiency, in whom the pathologic changes are less obvious but the physiologic ones very definite, may be considered analogous to patients with definite diabetes, nephritis or heart disease, in whom the symptoms may depend as much on physiologic as on pathologic changes, and in which special tests may or may not be required before a diagnosis can be established. The frequency with which deficiency disease of moderate degree occurs has not been clearly established, but these conditions are apparently common enough to be encountered by most physicians at fairly regular intervals, and to constitute at present the usual case of vitamin deficiency disease.

In a third group may be placed those conditions in which the deficiency is mild and in which recognition of the deficiency may be said principally to depend upon physiologic or chemical alterations rather than on pathologic ones. In fact, recognition of this group of cases in which clinical changes are often absent has depended on the development of special tests, such as the biophotometric determination of dark adaption of the eyes in vitamin A deficiency and the chemical measurement of the saturation of the tissues with vitamin C. The clinical significance of this group of "deficiency states" has not been settled. To carry further the previously mentioned analogy, one might say that this group corresponds to those diabetics in which the diagnosis can be made only after careful studies of the tolerance to dextrose, or with those nephritics who do not present clinical signs of renal

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* Read before the Pediatric Section of the California Medical Association at the sixty-seventh annual session, Pasadena, May 9-12, 1938.

TABLE 1.—*The Character of Vitamin-Deficiency States*

Degree of Deficiency	Clinical Signs	Essential Changes	Incidence	Diagnosis
Marked	Classical Deficiency Disease	Extensive Pathologic	Rare	Clinical findings
Moderate	Variable	Pathologic and Physiologic	Occasional	Clinical findings Laboratory tests
Mild	Absent? Preclinical?	Physiologic	Common	Laboratory tests

disease and in whom the diagnosis depends on careful study of the urinary sediment or of the ability to concentrate urine.

It seems probable that deficiency states falling into the third group will prove to be quite common. However, until much more evidence has accumulated in regard to the physiologic activity of the vitamins, until there are clear-cut methods of determining the chemical concentration of them in tissues and body fluids, and until the nutritional significance of slightly abnormal values are known, it will be impossible to state, in the case of a single individual, the clinical significance of such a slight deficiency.

METHODS OF PRODUCTION OF DEFICIENCY DISEASES: TYPES OF PATIENTS

It is commonly believed that vitamin-deficiency diseases occur only when the diet is inadequate. While this is probably the most common cause of deficiency disease, there may be other factors of etiologic importance, such as an increased demand for vitamins during pregnancy, during fever and when the basal metabolism is increased, such as loss of or destruction of vitamins after ingestion, and such as abnormalities in gastro-intestinal function. (Table 2.) During pregnancy and lactation, for example, the need for certain vitamins may be increased from 10 to 100 per cent, or even more above the requirement for the normal person.

Vitamin-deficiency states should be looked for particularly among those patients who have been on an inadequate diet in an attempt to reduce weight, or due to alcoholism, economic difficulties, faddism, or to poor therapeutic dietary advice, such as long-continued elimination diets, diets for gastro-intestinal diseases, allergic conditions, and so forth. (Table 3.)

THE DIAGNOSIS OF DEFICIENCY STATES

In considering the diagnosis of deficiency disease it is important to keep in mind the fact that the clinical features of a deficiency disease may vary within wide limits. This is due to the fact that there is great individual variation in the response of patients and also experimental animals to the same deficiency diet, and that it is questionable if a vitamin-deficiency state ever exists in pure form. There is almost always deficiency of more than one of the vitamins in a single patient. In fact McCollum and Simmonds pointed out some time ago that it is questionable if a pure vitamin-deficiency state, with the possible exception of scurvy, ever has been produced in the experimental animal.

The diagnosis of vitamin-deficiency states depends principally on clinical observations, although there is rapidly accumulating laboratory evidence to suggest that certain chemical or biologic tests may be useful in substantiating the diagnosis, or in establishing it in the absence of clear-cut clinical findings. A therapeutic test also may be of considerable value as diagnostic procedure, for now that some of the vitamins may be obtained in crystalline form, the specific response to use of a pure form of a vitamin may be considered significant in establishing a diagnosis in some cases.

VITAMIN A DEFICIENCY

Symptoms.

The most readily appreciated clinical symptoms of vitamin A deficiency have to do with changes occurring in the eyes. These symptoms consist principally of night blindness or inability to see clearly in dusky light, and of irritation of or lesions of the conjunctivæ. In its most exaggerated form, xerophthalmia (which is rarely observed in this country), there may be dryness of the conjunctival tissues, conjunctivitis, softening of the cornea, infection of the eyeball, and blindness.

Night blindness, which occasionally may be due to intra-ocular disease such as retinitis pigmentosa, is usually manifested by difficulty or inability of the patient to adapt his vision to faint illumination, although during the daytime or in bright light he may see perfectly. In questioning a patient in re-

TABLE 2.—*Vitamin, Protein and Mineral Deficiency States May Be Produced as a Result of:*

1. Inadequate intake of essential substances in the diet.
2. Increased requirements during periods of rapid growth, pregnancy, infections, fever, elevated basal metabolic rate.
3. Impaired or altered gastrointestinal function.
4. Altered metabolism of the vitamin.

TABLE 3.—*Suspect and Look for Deficiency States*

When the diet is inadequate because of:
1. Economic difficulty
2. Eccentricities, faddism, ignorance, alcoholism
3. Anorexia, dyspepsia, dysphagia, pain
4. Therapeutic dietary inadequacy

In association with or during
1. Gastro-intestinal diseases
2. Pregnancy, Infection, Hyperthyroidism

TABLE 4.—*Vitamin A Deficiency*

Degree of Deficiency	Clinical Signs	Incidence	Tests
Marked	Xerophthalmia	Very rare	
Moderate	Night blindness Skin lesions Conjunctival lesions Epithelial lesions of mucous surfaces	Rare	1. Biophotometer 2. Scrappings of mucous surfaces
Mild (Preclinical?)	Absent	25 to 75 per cent of all children and adults?	3. Therapeutic

gard to night blindness, particular attention should be paid to vision while driving a car at night, while in a theater or the movies, while walking at night or in the dark, or on entering a house from the bright sunlight. Such patients are apt to bump into things while walking at night, to have difficulty in driving a car at night because they cannot see the road or are dazzled by the lights of an approaching car, or to have difficulty in distinguishing facial features, the hands of a clock, or details of a picture, on entering a dimly lighted room.

A history of conjunctival irritation or dryness, which cannot be explained otherwise, may be obtained in some patients with vitamin A deficiency. Examination of the conjunctivae may reveal pigmentation, or there may be dryness or a granular appearance to the conjunctiva if the lids are held away from the eyeball for a few moments.

There has been discussion of the relation of vitamin A deficiency to cutaneous lesions, to lesions of the genital or urinary tract, and to states of lowered resistance to infections. Since deficiency of vitamin A characteristically leads to thickening or keratinization of epithelial tissues, followed frequently by secondary infection, it might be anticipated that cutaneous lesions would occur in vitamin A deficiency. The characteristic change, which is considered by some authorities to be the first manifestation of deficiency, consists of keratinization of a hard, dry papular type that resembles goose flesh and is most marked on the exterior surfaces of the forearms, legs, and thighs. A somewhat similar keratinization of the mucous membrane of the vagina, leading to a lesion resembling that of atrophic or senile vaginitis, has been reported in vitamin A deficiency. The relation of vitamin A deficiency to renal lithiasis in man is still indefinite, and while there is evidence to substantiate the view that in some cases renal lithiasis may be related to deficiency of vitamin A, in most instances of stone this does not seem to be the case.

The only recognized anti-infective influence vitamin A possesses is in maintaining normal epithelium, which will act as a barrier to infection; and since, so far as is known, the vitamin does not have any influence on immunological processes, it seems obvious that vitamin A in reality is not an anti-infective vitamin.

Diagnosis.

Principal interest at present in the diagnosis of vitamin A deficiency is in the detection of states of mild or partial deficiency in which the clinical diagnosis is not easy (Table 4). When the physician is confronted by a patient whom he suspects may have vitamin A deficiency, he should inquire into the presence of night blindness; and on examining the patient he should look for dryness or pigmentation of the conjunctivae and for a papular cutaneous eruption involving particularly the limbs, especially the exterior surfaces.

If vitamin A deficiency is suspected, there are three methods of diagnosis which may be employed in an attempt to confirm the clinical history suggesting that a deficiency exists or to suggest its presence in the absence of clinical findings. There are (1) a study of the sensitivity to light following partial adaptation to darkness, as determined by biophotometric methods of Jeans and Zentmire; (2) scrapping of the conjunctival, nasal or vaginal mucous membrane, making smears and examining them for keratinized epithelial cells; and (3) administration of vitamin A in crystalline or concentrate form. These methods are all relatively indirect, but if either of the first two tests proves to be positive, and if there is disappearance of these signs or of previously noted night blindness or cutaneous or conjunctival symptoms following administration of vitamin A or carotene, the diagnosis of vitamin A deficiency seems reasonably well established.

Physical and chemical methods for determining the vitamin A content of body fluids and tissues have been developed, but have not as yet proved satisfactory for clinical detection of vitamin A deficiency.

The diagnosis of very mild or "preclinical" deficiency of vitamin A in which clinical signs are absent is made at present only by use of the biophotometer. Patients who have no clinical evidence of vitamin A deficiency, but who have defective adaptation to darkness as revealed by this test, and who have normal adaptation after administration of vitamin A, are considered by some observers to have mild deficiency of vitamin A. The frequency with which "clinic populations" have a positive test with this method is in the neighborhood of from 50 to 75 per cent of all those tested, but the clinical significance of this observation has not been established.

Treatment.

Deficiency of vitamin A usually may be prevented by the use of adequate amounts of the following foods rich in vitamin A or carotene: butter, cream, eggs, cod-liver oil, carrots, and spinach. Fish-liver oils which are particularly rich in vitamin A are those of the halibut, cod, burbot, and tuna.

The daily optimal requirement of vitamin A is not known, but it is probably in the neighborhood of 6,000 to 10,000 U. S. P. units. In the treatment of vitamin A deficiency states, the following measures are of value: (1) a diet containing many foods rich in vitamin A; (2) supplements to the diet of

TABLE 5.—*Thiamin Deficiency (Vitamin B_1)*

Degree of Deficiency	Clinical Signs	Incidence	Tests
Marked	Beriberi	Rare	
Moderate	Peripheral neuritis Cardiovascular disturbances Edema Gastro-intestinal dysfunction?* Anemia?*	Infrequent	1. Calculations Cowgills Formula 2. Therapeutic 3. Amounts of Thiamin in blood and urine
Mild (Preclinical?)	Uncertain mild degree of above	Unknown	

* Changes in these organs are very frequently associated with thiamin deficiency, but are probably due to deficiency of components of the vitamin B complex other than thiamin.

vitamin A in cod or halibut-liver oil in amounts of 10,000 to 25,000 U. S. P. units daily (Jeghers suggests 70,000 U. S. P. units orally for two weeks, and the 25,000 units until the patient is normal); (3) in rare instances by intramuscular injection of cod-liver oil or other substances rich in vitamin A.

VITAMIN B_1 (THIAMIN) DEFICIENCY

Symptoms.

Thiamin is a catylist essential for the oxidation of carbohydrates, and when it is not present in adequate amounts in man the characteristic symptims of peripheral neuritis, circulatory failure, and beriberi occur. (Table 5.)

As Strauss and others have indicated, the diagnosis of alcoholic, diabetic, biliary, gastrogenic and postinfective polyneuritis, polyneuritis of pregnancy, and of Korsakoff's syndrome, have all concealed the true diagnosis of thiamin (vitamin B_1) deficiency. While symptoms of these conditions may be sudden in onset they are generally insidious, and the earliest manifestations usually are heaviness in the legs and tenderness of the calf muscles when they are squeezed. Weakness of the limbs, burning of the soles, and numbness of the dorsum and lower part of the ankles, are next to appear, followed by hypesthesia, which advances up the leg and thigh, and by atrophy of the muscles and of the skin. With these symptomatic changes there usually are associated diminished or absent reflexes in the involved extremities and various degrees of muscle weakness.

The cardiovascular manifestations of thiamin deficiency have been extensively studied by Weiss and Wilkins, and consist principally of dyspnea and palpitation on exertion, tachycardia, and edema. In cases in which the deficiency is greater the clinical picture may be that of cardiac failure with an enlarged area of cardiac dullness or an enlarged shadow on the roentgenogram, signs of right or left heart failure, and extensive edema or anasarca with or without signs of peripheral neuritis. It is obvious that in the absence of marked changes these manifestations do not, for the present at least, comprise a rigid and easily recognized clinical syndrome.

Other manifestations of thiamin deficiency which have been reported over a period of years include gastro-intestinal changes such as anorexia, glossitis, achlorhydria and diarrhea, and changes in the blood such as those indicating anemia. As Strauss has pointed out, there is considerable evidence to suggest that these phenomena are, at least in part if not entirely, manifestations of a deficiency of some portion of the vitamin B complex other than thiamin.

Diagnosis.

The diagnosis of well-established thiamin deficiency is simple if the characteristic triad of symptoms of beriberi, namely, edema, peripheral neuritis and cardiac failure, is present.

The diagnosis of a moderate degree of thiamin deficiency is usually not difficult, and with increasing recognition of the fact that peripheral neuritis is usually due to thiamin deficiency, the diagnosis is being made much more commonly than it was a few years ago. Recognition of cardiovascular symptoms as being due to thiamin deficiency has been a much more recent development and, because of this fact and the nonspecific character of the symptoms and findings, namely, dyspnea and palpitation on exertion, edema, and circulatory failure, the diagnosis is more difficult to establish.

Thiamin deficiency is usually to be found in chronic alcoholics, among patients who have been on a limited diet as a result of economic disability, faddism, ignorance or in an attempt to reduce weight, and during pregnancy and lactation.

There are no laboratory procedures which are helpful in determining the adequacy of the thiamin metabolism of a patient. Recently, several biologic tests revealing the apparent thiamin content of tissue fluids or of urine have been developed, but they are not of sufficient simplicity and perhaps accuracy to permit their use in the ordinary clinical laboratory. However, there are two other methods which will enable the physician to suspect that symptoms of his patient are due to thiamin deficiency. These are the calculations of Cowgill's formula and the therapeutic test. In cases in which the previous diet is known, an estimation of the adequacy of the thiamin content of the diet, as compared with the requirement of the patient, may be made by Cowgill's formula. Cowgill has shown that the requirement for thiamin is proportional to both intake of calories and body weight.

The therapeutic test with thiamin may be very useful in establishing a diagnosis of previous deficiency, but great care must be exercised in regard to the interpretation of the clearing up of cardiovascular symptoms, because frequently associated methods of treatment such as rest in bed, sedatives, digitalis, and psychic influences, may be the significant curative factors.

Evidence for thiamin deficiency of very mild character has not been established because of lack of chemical or other direct methods of determining the status of thiamin metabolism in patients with clinically recognizable deficiency.

Not infrequently, in association with thiamin deficiency, will be found evidence of deficiency of other components of the vitamin B complex,

Table 6.—*Vitamin B Deficiency (Other than in Thiamin)*

Clinical Changes	Deficiency of	Tests
Pellagra	Nicotinic acid Thiamin Other factors?	Therapeutic only
Macrocytic anemia	Uncertain	Therapeutic only
Gastro-intestinal: glossitis, anorexia, achlorhydria, hypotonicity, hypomotility	Uncertain	Therapeutic only

such as gastro-intestinal symptoms or macrocytic anemia. These symptoms and findings may prove helpful in establishing the correct diagnosis.

Treatment.

In the treatment of thiamin deficiency the exhibition of all of the following measures will be found most helpful: an adequate diet high in vitamin B content, preparations of brewers' yeast or wheat germ and crystalline thiamin chlorid. While crystalline preparations are available they should not, for two reasons, be used exclusively in the treatment of thiamin deficiency: first, because, as has been pointed out, most patients with thiamin deficiency have evidence of deficiency of other components of the B complex, and secondly, because crystalline thiamin chlorid is still quite expensive.

For those patients with only moderate deficiency, and without evidence of impairment of gastro-intestinal function, the use of 30 grams of powdered brewers' yeast of good potency, or 6 grams of autolyzed yeast, administered three times daily, is generally adequate. Along with this should be a high caloric, high vitamin diet, if it can be tolerated, and from 10 to 40 milligrams of thiamin chlorid daily, intramuscularly or orally administered. For those patients with severe cardiac symptoms, daily intramuscular or intravenous injections of similar doses of thiamin may be advisable. In addition, dilute liver extracts, suitable for intramuscular injection, given in doses of 10 to 20 cubic centimeters or more daily, are helpful in controlling glossitis and cutaneous manifestations of the type associated with pellagra. As soon as the patient shows evidence of distinct improvement, the dose of crystalline thiamin may perhaps be reduced to 10 to 15 milligrams daily; but it is advisable to maintain large doses of thiamin and other portions of the vitamin B complex, in the form of food and of yeast and wheat germ.

DEFICIENCY OF VITAMIN B (OTHER THAN THIAMIN)

The vitamin B complex consists of a variety of factors other than thiamin, such as riboflavin, the P-P factor (nicotinic acid?), a filtrate factor, vitamin B_6, and others. However, so far only two members of the complex, namely, thiamin and the P-P factor, have been linked unquestionably with deficiency disease in man. (Table 6.)

490 Post Street.

(To be continued)

THE ROENTGEN DIAGNOSIS OF DISEASES OF THE ILEOCECAL REGION OF THE GASTRO-INTESTINAL TRACT*

By Joseph Jellen, M.D.
Los Angeles

PART I

INTRODUCTION

There are a large number of disease entities which characteristically affect, and show a special predilection for, the ileocecal region of the gastro-intestinal tract. The purpose of this communication is to present a topographical classification of these conditions, in an attempt to facilitate the roentgen diagnosis. The conditions which are noted in the ileocecal segment of the intestine present a varied symptomatology, and differentiation on a clinical basis alone is difficult. In many instances, the diagnosis rests ultimately on the roentgen examination. The differentiation is particularly difficult in those instances where there is a history of pain in the right lower quadrant of the abdomen, associated with a palpable mass. Many of these conditions present a very similar roentgen appearance, and it is only by a consideration of all the possibilities, that we may hope to arrive at the proper diagnosis. In this regard, a topographical classification would seem to be of value.

A CLASSIFICATION OF DISEASES AFFECTING THE ILEOCECAL REGION FROM THE ROENTGENOLOGICAL STANDPOINT

I. Congenital Anomalies.
    (a) Transposition of the colon.
    (b) Anomalies of descent of the cecum.
    (c) Inverted cecum.
II. Ileocecal Bands.
    (a) Congenital.
    (b) Adhesions (postoperative).
III. Benign Tumors.
    (a) Fibroma.
    (b) Adenoma.
    (c) Papilloma.
    (d) Lipoma.
    (e) Angioma.
    (f) Myoma.
    (g) Carcinoid (argentaffine tumors).
    (h) Endometrial implants.
    (i) Mucous cysts.
IV. Malignant Tumors.
    (a) Carcinoma.
    (b) Sarcoma.
V. Specific Granulomas.
    (a) Ileocecal tuberculosis (primary and secondary).
        1. Ulcerative.
        2. Hyperplastic.
    (b) Actinomycosis.
    (c) Amebiasis.
        1. Amebic colitis (localized or diffuse).
        2. Amebic granuloma.

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* From the Department of Radiology of the Queen of Angels Hospital, Los Angeles.

Read before the Radiology Section of the California Medical Association at the sixty-seventh annual session, Pasadena, May 9-12, 1938.

VI. Nonspecific Granulomas.
  (a) Nonspecific ulcerative granulomas (acute, subacute, and chronic).
    1. Regional ileitis.
  (b) Inflammatory granulomas secondary to
    1. Appendicitis.
    2. Typhlitis.
    3. Cecal diverticulitis.
  (c) Peri-intestinal granulomas (secondary to perforations of the bowel, *i. e.*, by fishbone or toothpick).

VII. Lymphoblastoma.
  (a) Hodgkin's disease.
  (b) Lymphosarcoma.
  (c) Follicular lymphoblastoma.

VIII. Appendiceal Infections.
  (a) Appendicitis.
  (b) Fecaliths of the appendix (calcified).
  (c) Appendiceal abscess.
  (d) Mucocele of the appendix.

IX. Intussusception.
  (a) Ileocecal.
  (b) Cecocolic.

X. Diverticulosis.
  (a) Diverticulitis of the cecum.

XI. Mesenteric Adenitis.
  (a) Nonspecific.
  (b) Associated with appendicitis, ileitis, etc.
  (c) Tuberculous.
  (d) Calcified.

XII. Localized Ulcerative Colitis (Proximal Colon Involved).
  (a) Specific.
    1. Amebic.
    2. Tuberculous.
  (b) Nonspecific.
    1. Localized hyperplastic colitis.
    2. Ulcerative colitis associated with regional ileitis.

CONGENITAL ANOMALIES OF THE COLON

Congenital anomalies of the proximal colon are occasionally noted in the gastro-intestinal examination. Nonrotation of the colon is found at times. More often, variations in the degree of descent and fixation of the cecum are observed. The changes noted often correspond to the habitus of the individual, and the large normal variation should be kept in mind before any symptoms are attributed thereto.

ILEOCECAL ADHESIONS

Adhesions in the ileocecal region may be either congenital or acquired. In the former category may be mentioned Lane's kink. In this condition there is angulation and constriction of the terminal ileum, due to the peritoneal reflection from the cecum. Formerly, there was great stress placed on the relation of the condition to chronic intestinal stasis. In the great majority of cases, adhesions are acquired and postoperative in nature. Perforated appendicitis with local peritonitis is a common cause for adhesions in the right lower quadrant of the abdomen. Adhesions secondary to adnexal disease in the female is also encountered. The condition is manifest, clinically, by abdominal pain, distention, and vomiting. In other cases there is evidence of varying degrees of intestinal obstruction.

The roentgen examination is of great value in the diagnosis. Loops of small intestine are matted together, and there is fixation noted during the roentgenoscopic examination. At times there is constriction of the terminal ileum with dilatation of the intestinal loops proximal to the involved area. There is usually a delay in small intestinal motility, and a barium residue may be noted in the ileum as late as twenty-four hours after the ingestion of the barium meal. A residue in the small intestine from nine to twelve hours after the ingestion of the barium meal is suggestive of delay in small intestine motility. The normal variation in motility must be considered before attaching significance to the roentgen findings.

BENIGN TUMORS

Various types of benign neoplasms are found in the ileocecal region. Raiford[1] reported a series of forty-eight neoplasms of the small intestine situated in the ileum. The following types of benign tumors, in order of frequency, were found: adenoma, argentaffine tumors, lipoma, fibroma, myoma, hemangioma, and accessory pancreatic tissue. These benign tumors are usually silent until they are fairly large in size, at which time they become manifest by intestinal obstruction. Benign intestinal polyps are occasionally found in the proximal portion of the colon, although they are found more often in the distal colon and rectum. These tumors, though benign in origin, are regarded as precancerous and potentially malignant. According to various statistics, the incidence of cancer in intestinal polyps ranges between 25 and 50 per cent. Roentgenologically, these benign tumors appear as well defined, circumscribed, filling defects in the barium shadow. The double contrast enema is of great value in the demonstration of these neoplasms.

MALIGNANT TUMORS

Carcinoma of the cecum is seen quite often, whereas malignancy of the adjacent ileum is rather uncommon. According to statistics, carcinoma of the cecum comprises about 15 per cent, and carcinoma of the ileum about 3 per cent of intestinal cancers. Occasionally, carcinoma of the cecum involves the adjacent ileum by direct extension. Carcinoma of the cecum is most often of the polypoid type, and the mass is usually palpable on physical examination. The tendency of these tumors to produce marked secondary anemia is well recognized. From the roentgenologic standpoint, these malignant tumors offer very little difficulty in diagnosis. The presence of an irregular filling defect in the cecum is quite characteristic. Malignancy of the ileum is usually manifest by intestinal obstruction.

ILEOCECAL TUBERCULOSIS

Intestinal tuberculosis may affect any portion of the gastro-intestinal tract. The disease, however, is most frequently present in the ileocecal region. Ulcerative ileocecal tuberculosis, secondary to active pulmonary lesions is well known. Hyperplastic intestinal tuberculosis is much less common than ulcerative type, and may, or may not be secondary to tuberculous lesions elsewhere in the body. The hyperplastic type is characterized by an annular thickening of the wall of the bowel, with resultant stenosis of the intestinal lumen. The most common symptoms are abdominal cramps and diarrhea. At times the clinical picture is that of an acute or subacute intestinal obstruction. On physical examination, a mass is very often palpable in the right lower quadrant of the abdomen. The roentgen findings in intestinal tuberculosis are characteristic, but not pathognomonic of the disease. In the ulcerative type, Stierlin's sign is noted. There is irritability, spasm, and localized hypermotility in the involved segment of intestine, and very little barium is retained in this portion of the intestines. In hyperplastic tuberculosis there is constriction and stenosis of the lumen, with obliteration of the normal mucosal markings. Occasionally, filling defects are noted, the appearance of which may simulate carcinoma.

ACTINOMYCOSIS

Actinomycosis of the intestine is often noted in the cecum, and it is present in this location in approximately 25 per cent of all cases. Pathologically, the cecum shows the same thickening as in the hyperplastic form of tuberculosis. Later, suppuration occurs, and the mass is replaced by a number of small abscesses in this region. The disease often spreads to, and perforates, the external abdominal wall, with the formation of chronic draining sinuses. The pus from the discharges contains the characteristic "sulphur granules," in which the ray fungus is demonstrated. Secondary involvement of other abdominal organs, particularly the liver, also occurs. Clinically, these cases must be differentiated from regional ileitis, as this disease is also characterized by persistent abdominal fistulae. In actinomycosis the roentgen examination reveals contraction of the cecum, and filling defects when the process is more advanced. Differentiation from hyperplastic tuberculosis and carcinoma of the cecum is difficult, and the ultimate diagnosis often rests on the demonstration of the ray fungus in the discharges.

AMEBIASIS

Amebic infection of the intestine occurs in two types. In the first, there is an ulcerative colitis of specific etiology which commonly involves the proximal colon. At times, the process spreads and involves the entire colon. Occasionally, there is retrograde involvement of the terminal ileum. The cecum is involved in approximately 85 per cent of the cases. The second type is characterized by the formation of localized granulomatous masses, which are found most often in the cecum and in the flexures of the colon. Gunn and Howard[2] report three cases of amebic granuloma of the colon, two of which involved the cecum. In this type there is marked thickening of the wall of the intestine, as a result of the large amount of granulation tissue present. Clinically, there is usually a palpable mass in the abdomen. The disappearance of these granulomatous lesions has been observed, after the administration of specific therapy for amebiasis. The symptoms of the ulcerative type are identical with nonspecific ulcerative colitis. Examination of the stools reveals the presence of the vegetative forms or cysts of E. histolytica. In the hyperplastic type, diarrhea is often absent, so that carcinoma is usually suspected. The roentgen appearance of amebic colitis is similar to the nonspecific type. The former should be suspected when the process is limited to the proximal colon. In some cases the roentgen examination of the colon with the barium enema is negative, particularly in the early stage. In other instances, irritability and spasm of the intestines are the only positive roentgen findings. In the hyperplastic type there are filling defects in the barium shadow, the roentgen appearance of which may simulate carcinoma.

(To be continued)

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SELECTIVE ANESTHETIC PROGRAM: ITS DESIRABILITY*

By Hall G. Holder, M.D.
San Diego

Discussion *by W. Le Roy Garth, M.D., San Diego; Edwin H. Kelley, M.D., San Diego; Charles F. McCuskey, M.D., Glendale.*

The proper conduct of the anesthetic is a prime factor in the uncomplicated and successful outcome of surgical treatment together with a carefully planned and executed operation. We are indebted to the pharmacologist and anesthetist for the introduction of many new and efficient agents and improved methods of administration. These have broadened the field of anesthesia, so that a fundamental knowledge of the scope of each is necessary on the part of the surgeon if he is to provide the best agent for his patient. This selection must not only take into consideration the type of surgical treatment contemplated, but also physical, psychic and emotional handicaps. The surgeon has available the consulting or referring physician in evaluating complicating organic disease and emotional reactions of the patient toward the prospective operation. However, just as the physician who recommends a surgeon to the patient takes a definite responsibility in the eyes of the patient and his family, so the surgeon and not the anesthetist is held directly responsible for all details of the surgical procedure. Most patients are informed, in a general way, of the progress of anesthesia and for the most part the type of anesthesia must be discussed and at least tentatively decided upon, together with facts concerning the operation, hospital accommodations, fees and other details of vital interest to him. The relation of patient and surgeon is direct and personal as a result of careful study and discussion of the problems of treatment involved. It is only fair to the anesthetist that the usual impersonal attitude toward his services be corrected and the function of the anesthetist as a consultant be explained, and any suggestions for the betterment or safety of the anesthetic program be communicated to the patient. This, I believe, can best be done on admission of the patient to the hospital by a formal visit and consultation with the anesthetist, at which time he should correlate his findings with those listed from physician, surgeon, and laboratory. If he does not agree with the anesthetic program outlined by the surgeon, mutual agreement on the best procedure may be arrived at and preparation commenced without further delay or upset to the patient.

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* Read before the Anesthesiology Section of the California Medical Association at the sixty-seventh annual session, Pasadena, May 9-12, 1938.

Having long been convinced of the desirability of varying the anesthesia to suit the individual circumstances, I reviewed the types of anesthesia employed in one thousand consecutive major operations in my private practice. This revealed that 9 per cent were given open ether, 25 per cent gas, oxygen, ether series, 11 per cent avertin basal (supplemented usually with nitrous oxid or ethylene and occasionally combined with ether or, in a few instances, with open ether), 9 per cent nitrous oxid alone, 12 per cent with ethylene alone, or a total of 21 per cent with these gases alone; 32 per cent spinal and 2 per cent local, including any other type of regional anesthesia.

With the present latitude of anesthetic procedure and its attendant advantage to patient and surgeon, empiric insistence on one anesthetic procedure by either anesthetist or surgeon is unprogressive. Observation would indicate that anesthetists favor inhalation anesthesia, while surgeons incline toward regional anesthesia where there is no contra-indication to its use. However, there should be no divergence of opinion because both have their distinct place.

INHALATION ANESTHESIA

Preoperative medication is routinely used, and I believe that split doses of barbiturates the night before and the morning of operation, with the usual dosage of morphin, or one of the newer derivatives with atropin or scopolamin, is standard procedure.

The proper technical administration of inhalation anesthesia has no interest for the surgeon. It is important for him to be conversant with the four planes of anesthesia, as in the average operation requiring one hour, perhaps only five or ten minutes need be third-plane anesthesia; so that by mutual understanding between anesthetist and surgeon unnecessary and prolonged deep anesthesia may be avoided, with distinct benefit to the patient. Anesthetists, by their use of the intratracheal catheter, have produced quieter and smoother anesthesia for upper abdominal surgical procedures. Likewise, by the use of a basal anesthetic such as avertin difficult upper abdominal procedures requiring adequate anesthesia to perform a careful nontraumatizing operation is very helpful. More recently evipal soluble has been used and has the advantage over avertin of simplicity of preparation and administration with less toxicity. Both, in producing a satisfactory basal state, reduce the amount of supplementary anesthetic by one-third or even one-half. My patients uniformly praise avertin basal anesthesia; and if they have had previous anesthetics are unanimous in their opinion that the onset of anesthesia while lying in bed prior to leaving their room is far superior to any other type of induction. Obviously, this is the method of choice in apprehensive and nervous individuals and the one which I use in this type of patient if possible. Also, the continued period of analgesia following operation allows these patients, in most instances, to completely recover from any initial pain or shock as a result of the operative procedure before they regain full consciousness.

Even with adequate preparation not infrequently a patient tolerates an inhalation anesthetic poorly. The mistake is made by the anesthetist in delaying the change to a better-tolerated one, it being a matter of pride with some anesthetist that they can anesthetize any patient under any circumstance with one agent or method. It is obvious that it is unwise to push any type of anesthesia beyond its limitations. This particularly applies to the use of gases alone in attempting adequate anesthesia for intra-abdominal procedures. When this is attempted without associated basal anesthesia, the end-result is insufficient relaxation to permit adequate exposure without undue trauma, a poor anesthesia, and a poorly done operation. The worst feature of the anesthesia is the necessity on the part of the anesthetist to increase the concentration of gas in a vain effort to obtain adequate relaxation to the point of resultant cyanosis. There seems to be good evidence that the narcotic action of nitrous oxid is enhanced by some degree of anoxemia. Inasmuch as it must be given in high concentration, the administration is frequently accompanied by cyanosis. It is appreciated that there is a difference of opinion among good anesthetists whether any clinical cyanosis in gas anesthesia is harmful; but as far as my own patients are concerned, I prefer to adhere rigidly with those claiming any degree of clinical cyanosis bad practice and unnecessary to proper administration. My conviction in respect to this point of view has not been lessened by the several reports of severe degeneration of the brain with subsequent death following nitrous oxid and cyclopropane anesthesia. Two recent reports by Gebauer and Coleman,[1] and O'Brien and Steegman,[2] detail cases of cerebral necrosis with death in the first instance with cyclopropane, and the second, nitrous oxid, in which there was no clinical cyanosis. Courville,[3] in discussing the pathogenesis of cerebral necrosis in this connection, points out that the weight of opinion supports asphyxia as the cause rather than any toxic or narcotic action of the gas. Further emphasis of this point is had by a clinical death from this syndrome in my own practice. The patient, an elderly woman, took a very poor nitrous oxid anesthesia, as evidenced by periods of cyanosis subsequent to periods of temporary arrest of respiration. Postoperative clinical evidence of cerebral damage, which, unfortunately, we could not confirm by autopsy, was failure to regain consciousness, muscular twitchings, convulsive seizures, profound restlessness and hyperthermia, death resulting in five days.

The value of these agents has been demonstrated beyond doubt, but the importance of careful administration and a knowledge of their limitation is equally vital to all concerned. The value of versatility and adjustments of agents, or combination of agents or methods, to physical or psychic tolerance on the part of the patient is equally important. The value of basal anesthesia and improved methods of technique, such as the intratracheal catheter for upper abdominal, and head and neck surgery, especially in the presence of fire hazards, needs no further comment.

My experience with intravenous agents has been limited to short procedures. It is entirely safe with careful administration, and is of definite advantage because of the prompt return to consciousness without nausea and vomiting. Patients should not be dismissed until entirely recovered or properly attended. Its simplicity makes it very useful for office cases, and its freedom from fire hazard is helpful in cases requiring high-frequency cutting or the cautery.

SPINAL ANESTHESIA

As noted, spinal anesthesia was employed in 32 per cent of cases. It is an established fact that it provides the most ideal conditions for the technical performance of surgical procedures. Further, it is acknowledged to be the anesthetic of choice in a number of surgical conditions, provided there are no contraindications to its use.

Fourteen years' observation of many hundreds of spinal anesthesias provides a knowledge of only two deaths from this agent, one directly due to the anesthetic and the other to coronary thrombosis confirmed at autopsy, possibly precipitated by the anesthetic. No other residual sequelae or complications have come to my attention. It is, therefore, disturbing from time to time to read reports[4] of clinical changes in the nervous system, and of associated sequelae and complications following spinal anesthesia. If these have occurred in my practice, they have gone unrecognized by the patient and myself. The only conclusion I can reach—if such reports are authentic, which they undoubtedly are—is that gross error in technique must be responsible for their occurrence. Likewise, Davis et al.[5] reported persistent changes in the structures of the spinal cord of dogs, to which had been administered varying doses of spinal anesthetic agents through a ninety-day period. These changes were given as inflammatory reaction in the leptomeninges, passive changes in the ganglion cells, swelling and fragmentation of the axis cylinders, and degenerative changes in the fiber tracts of the cord.

Although there were no clinical manifestations of such changes in my patients, I felt such findings were a serious indictment of spinal anesthesia and undertook to confirm these histologic studies, using a total of twenty-two dogs. I was not interested in the reaction of the structures in the cord to massive doses of the various agents, but rather the reaction to a comparable dose given man. We were unable to do accurate and atraumatic spinal puncture in the dog, as Davis and his associates so resorted to laminectomy in each instance. Two animals developed wound infections and were discarded and two were used as controls. Six dogs, varying in weight from 8 to 24 kilograms, were given, in the lumbar region, from 15 to 45 milligrams of dissolved novocain crystals, using spinal fluid, and destroyed from four to thirty days, the cords carefully removed and fixed in Muller's solution. A second series of six dogs, varying in weight from 14 to 24 kilograms, were administered by the same technique amounts of nupercain, varying from 0.4 to 0.7 cubic centimeter, and destroyed at similar intervals. The third group of six dogs, varying in weight from 8 to 45 kilograms, received, by a similar method, doses of from 0.3 to 0.6 cubic centimeter of a mixture of 50 milligrams of novocain and 2 cubic centimeters of nupercain, the cords being removed at intervals, as in the other series. This latter combination was studied because of my interest and report[6] of its advantage in obtaining faster onset of anesthesia when nupercain was employed. The segments of the cord were treated with Marchi stain for detection of myelin sheath degeneration, and hematoxylin-eosin for general configuration and meningeal examination; Nissl stain for nerve cells and cytoplasmic granules; Bielschowsky silver stain for collogen fibrils, axis cylinder and dendritis; Weirgert-Pal stain for medullary sheath; and Weirgert stain for fibrin and glia fibers. These sections, taken at different levels throughout the cord, were examined by Dr. Earl Meyers, who was associated with me in this work. Any controversial sections were submitted to others for opinion, and it was their combined report that no pathological changes were present in the structures of the cord as a result of these therapeutic doses. It is to be remembered that nupercain is reported to be many times more toxic than novocain, although in the therapeutic doses used, no toxic effects could be demonstrated.

Koster,[7] using frogs because of the simplicity of injecting the urostyle without trauma, administered sublethal doses of novocain to 528 frogs. These animals were then destroyed from one hour after administration at regular intervals up to one hundred days, and similar histologic studies made of the spinal cord. He noted transitory changes in the structures of the cord, which began to regress in six hours and entirely disappeared in twenty-four hours. In the same report Koster relates the similar examinations of six human spinal cords of patients dying of other causes, following the administration of spinal anesthesia. The time interval following anesthesia in these cases was 22, 36, 96, 144, 192, and 816 hours. In no instance was there any demonstrable histologic change from the normal. Similar confirmation of Koster's findings is to be had in the works of van Lier,[8] Wassildo,[9] Babcock,[10] Pitkin,[11] and Lundy, Essex and Kernohan.[12]

From clinical observation and histological examination of animal and human spinal cords, we can conclude without reservation that spinal anesthesia is devoid of injury or sequelae if properly administered.

In preparation for spinal anesthesia I use the same combination of drugs as for inhalation anesthesia, with the addition before administration of ephedrin to minimize blood-pressure fall. If it is then advisable to supplement with one of the gases, because the patient objects to the conscious state or the spinal anesthesia is not adequate, this can be done immediately. If it is important or desirable from a surgical standpoint to use spinal anesthesia, one need not fear the combination of inhalation agents for the comfort of the patient at any time during the course of the operative procedure. The idea that, because patients have had a satisfactory spinal anesthesia, they must endure fatigue, aprehension and psychic trauma through their experience and surroundings is unfeeling. I therefore purposely supplement a large percentage of my spinal anesthesias with narcotic doses of the gases, knowing the patient is comfortable at the same time having the superior effect of the spinal for the surgical problem at hand. In this enlightened age of anesthesia our patients expect, and have a right to demand, comfort and freedom from pain regardless of the surgical condition. In this connection, to those patients to whom I recommend spinal anesthesia, I emphasize the fact that administration is absolutely painless. Therefore, the anesthetist must be thoroughly conversant with principles of spinal anesthesia and perform a painless, accurate and speedy spinal puncture.

The only postoperative morbidity that has been noted following spinal anesthesia is an occasional headache. These, with improved technique, have been reduced to a minimum of late years. As a matter of fact, the incidence of headache is as great, or greater, after inhalation anesthesia, particularly the gases, than following spinal anesthesia. Furthermore, the spinal headache may be relieved immediately by the simple intravenous injection of caffein sodium benzoate.

SUMMARY

1. The limitations of gas anesthesia are discussed and the hazards of cyanosis and anoxema stressed.
2. The psychic and practical advantage of rectal basal anesthesia is given.
3. The case for spinal anesthesia is presented and proof of its safety and freedom from sequelae with proper administration detailed.
4. The desirability of a careful individualization of patients in respect to anesthetic agents employed, considering psychic as well as physical status, is the principal theme. The closest coöperation of surgeon and anesthetist to provide maximum comfort to the patient consistent with the best end-result of surgical therapy should be the goal of both.

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DISCUSSION

W. Le Roy Garth, M.D. (233 A Street, San Diego).—Doctor Holder is to be complimented for having thought enough about this problem to write a paper on the subject. Many surgeons let habit get the best of them and allow themselves to fall into a rut regarding the proper selection of anesthesia for the individual patient. Anesthetists, themselves, easily develop bad habits in this respect, and should be properly grateful to a surgeon who refuses to let them do so in respect to his patients. However, they must disagree with Doctor Holden when he says that "the surgeon and not the anesthetist is held directly responsible for all details of the surgical procedure." This fallacy dates back, we believe, to the days of technician-administered anesthesia, when the surgeon really did have to superintend the administration of the anesthetic, and when he really did have to take the blame when things went wrong. We contend that the modern physician anesthetist should certainly be expected to relieve the surgeon of most of this burden and, if it comes to a showdown and there is a death on the table, the anesthetist must perforce be held equally responsible, with the surgeon and with the internist, for what has happened.

Regarding the types of anesthesia used in Doctor Holder's one thousand cases, it should be noted that this series extended over a period of several years, and that the proportions of the different types used at present would vary considerably from this list. The principal changes perhaps would be in the rapidly increasing use of cyclopropane, the practical abandonment of open ether, and in a considerable decrease in the percentage of spinal anesthesia used. In place of avertin, sodium evipal is used rectally as a basal anesthetic with increasing frequency.

Doctor Holder's insistence on the avoidance of cyanosis in connection with gas anesthesia has been, I believe, a definite factor in improving anesthesia practice in this locality. Momentarily, at least, cyanosis may be unavoidable, but the deliberate administration of a mixture of gases low in oxygen content should never be tolerated. Fortunately, there has been little temptation to do this since the advent of cyclopropane.

As indicated by Doctor Holder's experiments, and those of Koster and others, the possibility of lasting injury to the spinal cord in connection with spinal anesthesia is extremely remote. So remote, in fact, as to be in a class with the explosion hazard in connection with the use of ethylene and cyclopropane. The open-minded surgeon and anesthetist properly evaluate the slight risk involved in using these agents and methods, as compared with the tremendous advantages obtained, and insist on using them when indicated.

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Edwin H. Kelley, M. D. (1205 Medico-Dental Building, San Diego).—Doctor Holder speaks of a formal visit and consultation with the patient on his admission to the hospital and an anesthetic program decided upon. This, we believe, is very important because no one is more aware of the merits and limitations of the various types of anesthetics than is the anesthetist. Past experience has taught him the futility of giving nitrous oxid when cyclopropane is clearly indicated. Furthermore, most patients are more apprehensive concerning the anesthetic than the actual surgery.

We routinely use avertin, evipal or paraldehyd rectally in preoperative preparation. When avertin is used, 80 milligrams or less is given forty-five minutes before surgery, preceded by morphin sulphate, grain 1/6, and atropin, grain 1/150, fifteen minutes sooner. With paraldehyd, one cubic centimeter for every eight pounds of body weight in double the amount of olive oil is given two hours before surgery. One hour before surgery, the hypodermic is given and this consists of morphin sulphate, grain 1/6, and scopolamin, grain 1/150. An advantage of the latter is that the patient is sleepy nearly all day and is unaware of the elimination of the anesthetic agent. Nausea is much less common with this type of procedure. The Navy surgeons, in addition to either of the above methods, give prostigmin, ampoule 1/1 by hypodermic two hours before surgery. As a postoperative procedure they give glycerin, 5 cubic centimeters, by mouth every four hours for five days to prevent distention and supplement this with prostigmin, ampoules 1/1, every four hours for five doses in the most stubborn cases.

We use nitrous oxid only for induction, later changing to cyclopropane or ethylene, unless a cautery or radial knife is used, at which time nitrous oxid is used throughout. An added precaution of removing the ether jar and rinsing the rubber bag on the machine with water before the cautery is used is an aid in guarding against explosions.

Of the intravenous agents, pentothal sodium is preferable to evipal. However, when either is used in the office, not more than .5 gram should be used. Upward of this should be a hospital case. If either of these are to be used at the County Hospital, the patient is admitted for at least twenty-four hours and closely observed during the period following surgery. In one case there, a gunshot wound when the entire lower jaw, half the tongue and glottis were shot away, we used pentothal for three hours and ten minutes. Normal saline was started intravenously and the pentothal injected through the rubber tubing as needed. Nearly four grams were used.

Doctor Holder mentions Doctor Davis, who reported persistent changes in the structures of the spinal cord following spinal injection. We presume he means Loyal Davis, head of the Department of Surgery at Northwestern University. As a result of his experiments on dogs, spinal anesthetics in any form are forbidden in Passavant, the University Hospital. This seems absurd. We do feel a spinal should be given by an anesthetist who has the equipment, gas or carbogen, should the spinal prove ineffective or the surgical procedure carry beyond the time allotted a spinal. Ethylene added to a spinal before the skin incision is made is ideal.

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Charles F. McCuskey, M.D. (1561 Puebla Drive, Glendale).—Speaking from the viewpoint of an anesthetist, I should like to congratulate Doctor Holder on the variety of anesthetic procedures which he uses. It is certainly a great improvement over the program of many surgeons who adhere to the use of one anesthetic agent and method regardless of the type of operation or physical condition of the patient.

In our own practice, in addition to the variety of procedures enumerated by Doctor Holder, we have found regional block, alone or combined with gas or avertin, of value. Thyroid operations on the exophthalmic type or extremely toxic adenomas frequently do better with avertin plus local than with local alone. Abdominal field block for intra-abdominal operations on patients that appear too sick for spinal or peridural anesthesia will enable the anesthetist to produce sufficient relaxation without resorting to deep surgical anesthesia. Ethylene can be used for these cases without producing cyanosis or the addition of ether, but my own preference is cyclopropane.

It is well to keep in mind that the chief function of the blood is to carry oxygen to the tissues. In the presence of a low hemoglobin the oxygen carrying power is decreased. During spinal anesthesia the tidal exchange may be reduced from 40 to 60 per cent. Such patients should be watched carefully and given oxygen at the first sign of cyanosis.

Proper selection of the anesthetic agent and method of administration to suit the needs of each individual patient will undoubtedly reduce postoperative morbidity by twenty-four to forty-eight hours.

NUCLEUS PULPOSUS RUPTURE: LEGAL-INDUSTRIAL ASPECTS*

By Edmund D. Leonard, J.D.
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INDUSTRY'S liability, under the California Workmen's Compensation laws, where employees suffer ruptures of the nucleus pulposus, is not yet clearly determined. It will be definitely ascertainable in the future in direct ratio to the development and certainty of medical knowledge of the causes, the necessary treatment and the disabling effects of such ruptures. But it is possible now to state what the probable liability of industry will be under certain circumstances and to point out in this manner the legal problems which are now presented and which will arise in the future.

ACCEPTED INTERPRETATIONS

Where an employee receives a traumatic injury which in and of itself causes disability without preexisting disease or degeneration playing any part, the employer is liable for the entire disability resulting and for all medical treatment reasonably required to relieve the disability. But where injury is superimposed on a diseased or degenerative condition the employer is not entirely liable for all disability, but only for the disability attributable to the injury as distinguished from that attributable to disease. An employer is not liable for disability which is not due to industrial injury. He is not liable for disability due to the wear and tear of ordinary life, or to nonindustrial infection, degeneration or disease resulting gradually or immediately merely because such disability occurs while the employee is at work.

However, the law holds that an employer takes a man as he finds him. It does not assume that every employee is a perfect physical specimen. If an individual below par suffers an injury which would not disable a more robust man, and it yet does disable the subnormal individual, the employer is, nevertheless, liable. Thus it is that where industrial injury aggravates a preëxisting disease or a preëxisting diseased condition so as to cause disability, the employer is held liable for such proportion of the disability as is attributable to the aggravation.

AGGRAVATION OF PREËXISTING DISEASE

This liability for disability consequent on aggravation of preëxisting disease must be considered from two standpoints: first, as to temporary disability; and, secondly, as to permanent disability.

During the time the employee is temporarily disabled as the result of the aggravating injury, the employer must pay him compensation for his lost wages. He must also furnish him all necessary medical treatment reasonably required to cure and relieve him of the aggravating effects of the injury. If, then, after all reasonable medical treatment required (because of the injury) has been furnished, the employee has been returned to the same approximate condition as would have existed in absence of the injury, the employer has no further liability.

However, if the injury, superimposed on the preexisting condition, leaves a lasting or permanent disability greater than would have existed in absence of the injury, then the employee is entitled to monetary compensation for that proportion of his permanent disability attributable to the injury. But he is not entitled to disability benefits for that proportion of any permanent disability he may have which is solely attributable to preëxistent disease uninfluenced by injury.

The liability of an employer to furnish medical treatment is in all cases limited to the furnishing of only such medical treatment as is reasonably required to cure and relieve from the effects of industrial injury.

CLASSIFICATION INTO THREE GROUPS

The foregoing principles take into account three possible classes of cases:

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* Read before the Industrial Medicine and Surgery Section of the California Medical Association at the sixty-seventh annual session, Pasadena, May 9-12, 1938.

Paper by invitation.

1. Where disability results solely by reason of traumatic injury.
2. Where disability results by reason of a traumatic injury superimposed on preëxisting disease or degeneration.
3. Where disability results solely by reason of the natural progression of disease or of a degenerative process.

Whether cases involving rupture of the nucleus pulposus can be divided into these three classifications and, if they can, the factors upon which individual cases are to be allocated to one classification rather than to another, is the principal medico-legal problem involved. Secondarily, where it is found that industrial injury is partially or entirely responsible there is the question as to the nature and extent of medical treatment which must be afforded by the employer to cure and relieve from the effects of the injury. Lastly disability, both temporary and permanent, must be evaluated in cases where injury is a causative factor.

REASONS FOR CLASSIFICATION

In presenting to the medical profession the question of whether ruptures of the disc should be classified as industrial, partially industrial, or wholly nonindustrial, the attorney dealing with these cases is induced to ask the question by reason of some or all of the following facts: Within the last two years disabilities due to these ruptures have formed the basis of numerous claims presented to employers and their insurance carriers, with few, if any, such claims having previously been made. Investigation of these claims often fails to develop any definite history of trauma or injury, or a history of only minor strain or trauma. Considerable time may have elapsed between the injury claimed and the onset of disability, as so often happens in cancer cases where after diagnosis is made the patient then recalls a forgotten or unimportant injury as the causative factor. Previously, and coincident with the presentation of these claims, there have been a great number of claims presented involving severe injuries to the spine, with shock, fracture compression and distortion, although few, if any, of these have involved injury or destruction of the intervertebral disc. In the discussion of disc-injury cases currently presented with various physicians treating them, claims men and attorneys have been advised that, although there has been but limited research in this country, foreign investigation has shown postmortem evidence of disc rupture in many spines with no history of trauma. If, then, certain of these ruptures are wholly traumatic, if certain ones result merely from minor trauma to a previously diseased disc, and if others are due solely to progressive degeneration, it is important to establish these several facts before legal liability can be determined.

FIRST GROUP

Where there is a severe trauma with immediately resultant disability, and a ruptured disc is found to be the cause of such disability, there can be little question that industry is responsible for the medical treatment necessary to relieve the disabling condition and for monetary benefits to the employee while he is temporarily disabled. In such a case of severe injury and immediate disability the burden would certainly be upon the employer to show that the employee suffered some preëxisting disease contributing to the disability as a causative factor. Even then the liability of the employer would be reduced, if at all, only as to any permanent disability the employee might have, after all reasonable medical treatment had been rendered. But "severe trauma" means just that; not some normal or slightly unusual occurrence magnified to form the basis of a claim.

SECOND GROUP

Where a minor strain or trauma immediately precedes disability, and a ruptured disc is found to be the cause of such disability, then there is doubt as to whether there is any industrial liability and, if there is, the extent of such liability. The certainty and adequacy of the trauma should first unquestionably be established. It should be something more than an ordinary bodily movement or bodily contact without any added strain or trauma due to the peculiar requirements or hazards of the employee's work. If the adequacy of the injury immediately preceding the disability is established, the presumption would be that it was probably a contributing causative factor in producing the rupture. If it is established as such, the employer would be required to furnish all medical treatment reasonably required to cure and relieve from the effects of the injury.

Once all reasonable medical treatment was rendered, should the employee have persisting permanent disability it would be necessary to determine whether this permanent disability was greater than any he would have had in absence of the injury. To determine this it would be necessary to know what, if any, abnormal pathology existed prior to the injury, and would later have existed in absence of the injury; in other words, whether the ruptured disc was diseased or degenerated and, if so, to what extent at the time the injury was sustained. If it was diseased, had the employee a vulnerable back which should not have been subjected to excessive flexion or strain? Is his back any worse after injury and treatment than it would have been had he not been injured? If he has merely received conservative treatment, has his spine returned to the same condition as previously existed? If he has had a laminectomy, a fusion, or both, is his permanent condition better, the same, or worse than it would have been in absence of the injury and the surgery?

If his condition is no worse, then the employer should not reasonably be held for any permanent disability. For example, if an employee with degenerated discs should not do work involving lifting, bending or twisting, and such work would probably result in disability, his condition would not be impaired by a laminectomy and fusion, giving him a painless but partially rigid spine. In fact, in such instance he would probably be better off as to working ability, and the diseased condition would be eliminated as well. excluding the probability of future total incapacity due to its natural progression.

The nature and extent of medical treatment to be rendered in the event of a disc rupture due to injury is a question only of what is reasonable: whether it be conservative or surgical and, if the latter, the extent thereof, whether laminectomy or fusion or both.

THIRD GROUP

The third possible classification involves those cases which are nonindustrial or not attributable to injury; those cases where rupture occurs merely because of the progression of a diseased condition or degeneration of the disc. The mere fact that this rupture may occur on the job while the employee is doing his usual work would not entitle him to any benefits, monetary or medical. These cases would of necessity be distinguished by the absence of any adequate immediate injury and by the presence of degenerative pathology. Whether the former (the inadequacy of injury) would establish the latter (the presence of disease) is a consideration to be taken into account. Certainly, to a layman's mind the occurrence of rupture in absence of apparently adequate injury would point to a degenerative process as the sole causative factor.

But it will be important to affirmatively establish the presence of disease or degeneration in these cases apart from the history or absence of history of injury. This is particularly true where disability follows a doubtful or minor trauma. It is obvious that a patient's history, with the liability of the employer dependent on it, will often be open to serious question. Hence, if the diseased condition can be demonstrated by x-ray, clinically, surgically, or pathologically apart from and independent of the history, it will be of the utmost importance. History of severe trauma can often be woven out of whole cloth without possibility of contradiction. Normal acts and occurrences which would pass entirely unnoticed by an employee and his coworkers will, due to natural human reactions, assume monumental importance if the employee becomes disabled at or subsequent to the time they occur. If, therefore, reliable standards of diagnosis to determine the presence or absence and the degree of degeneration can be established apart from history, the major portion of the problem will be solved.

220 Bush Street.

ACTIVE INTERSTITIAL KERATITIS OF LATE PRENATAL SYPHILIS: ITS TREATMENT*

By C. Russell Anderson, M.D.
and
Warren A. Wilson, M.D.
Los Angeles

Discussion *by Harold F. Whalman, M.D., Los Angeles; William A. Boyce, M.D., Los Angeles.*

Interstitial keratitis is one of the most distressing, and one of the most common manifestations, of late prenatal syphilis. That it can be prevented is shown by the Coöperative Clinical Group,[1] who found that, among 243 patients adequately treated for prenatal syphilis (with at least sixteen injections of an arsenical and thirty-one injections or weeks of rubs of heavy metal) before the onset of interstitial keratitis, only five (or 2.1 per cent) subsequently showed it. On the other hand, of 884 patients with untreated syphilis, 314 (or 36 per cent) sought treatment because of interstitial keratitis.

THE THERAPEUTIC PROBLEM

Once that interstitial keratitis manifests itself, the syphilologist and the ophthalmologist are faced with a therapeutic problem. Should they treat the patient with routine intensive therapy with the arsenicals and heavy metals, or should they supplement this with nonspecific therapy, such as intramuscular injections of boiled milk, intravenous injections of typhoid-paratyphoid vaccine, malaria or artificial fever? The fact that nonspecific therapy is so widely used in the treatment of interstitial keratitis is an expression of the dissatisfaction of many with the usual chemotherapy.

Nonspecific Therapy.—Nonspecific therapy, with boiled milk or typhoid-paratyphoid injection, is well known and an accepted procedure in resistant keratitis.[1, 2] Malaria has been successfully used since 1928 by Schreiber,[3] Marchesani,[4] Albrich,[5] Kundratitz,[6] Granstrom,[7] Miller,[8] and Dennie, Gilkie and Pakula.[9] In 1934 Ambler and Van Cleve[10] reviewed the literature on the use of malarial therapy, and reported the use of malaria, in seventeen cases of interstitial keratitis during a six-year period, with gratifying results. They felt that malaria possessed a distinct advantage over any known treatment. In their series two cases suffered relapses—one a month after malarial therapy with rapid response to typhoid-paratyphoid injections, and the other two months after malaria therapy and responding to three injections of boiled milk. Five of their patients had only one eye involved when malarial therapy was instituted; in none did the other eye become involved. Cole[2] also has recently recommended malaria, especially in old resistant keratitis.

Chemotherapy.—On the other hand, Stokes,[11] Carvill and Derby[12] and Carvill,[13] Robinson,[14] and the Coöperative Clinical Group[1] have reported satisfactory results with chemotherapy. Moore,[15] although having no personal experience with nonspecific measures, believes that those who resort to nonspecific therapy do so because of their failure to make the antisyphilitic treatment intensive enough.

Authors' Procedure.—Impressed with the report of Ambler and Van Cleve,[10] and dissatisfied with the usual chemotherapeutic procedure in the treatment of interstitial keratitis, beginning in July, 1936, we added malarial therapy to our armamentarium, along with intravenous typhoid-paratyphoid injections. Since then, we have administered fever therapy to twenty-two patients, sixteen of whom received malarial therapy and six intravenous typhoid-paratyphoid injections.

The youngest patient was four years of age and the oldest forty-four years of age. There was one patient in the first decade, sixteen in the second, two in the third, two in the fourth and one in the fifth decade. Fifteen of the patients were women or girls, and seven were men or boys. There were thirteen Mexicans, five Negroes, three whites and one Chinese.

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* From the departments of Dermatology and Syphilology, and of Ophthalmology, of the Los Angeles County General Hospital.

A preliminary report with special reference to the use of malarial treatment.

Read before the Dermatology and Syphilology Section of the California Medical Association at the sixty-seventh annual session, Pasadena, May 9-12, 1938.

Six of the twenty-two (or 27.2 per cent of the patients) had negative serologic reactions of their blood. This immediately suggests that all individuals with latent prenatal syphilis, regardless of the serologic reaction of the blood, should have treatment, probably as outlined by the Coöperative Clinical Group, for acquired late latent syphilis. No patient had clinical evidence of neurosyphilis, although two had positive spinal fluids of meningovascular type. All had some stigma of prenatal syphilis, although only sixteen had Hutchinsonian incisors. Only three of the patients had had antisyphilitic treatment before the onset of the interstitial keratitis, and all of it extremely inadequate.

Under the classification of the Coöperative Clinical Group,[1] the time limit for acute lesions is set at two months or less, and chronic lesions are classified as active manifestation of duration longer than two months. The Coöperative Clinical Group[1] found that the acute stage of interstitial keratitis usually responded to the first few injections of arsphenamin and to treatment with a heavy metal. There immediately arises the question as to whether our use of fever therapy is justified in cases of acute interstitial keratitis? On examining our twenty-two cases, we found that seven were seen in the acute stage, and antisyphilitic treatment with arsphenamin and heavy metal instituted. Six of these received continuous antisyphilitic treatment for periods of from two to six months without relief before fever therapy was instituted, and during this interval there was involvement of the second eye in three cases. The seventh patient had three relapses during a four-year interval, in spite of vigorous treatment, and negative serologic reaction on the blood. Incidentally, all seven responded immediately to fever therapy. Six were given malarial therapy, and one—a four-year-old child—was given typhoid-paratyphoid vaccine intravenously. Three of these patients were followed for one year or longer. Two had complete clearing of the corneas. The third had complete clearing of one cornea, minimal residual opacities remaining in the other cornea.

PROCEDURE

A course of malaria consists of from eight to fourteen paroxysms. Usually intravenous typhoid-paratyphoid injections are given to the patient after inoculation until malaria paroxysms appear. After completion of a course of malaria, antisyphilitic treatment is started with an arsphenamin. A course of typhoid-paratyphoid consists of from eight to twenty paroxysms of 103° or over. The treatment time was prolonged in some cases because satisfactory rises in temperature were not consistently obtained in each administration of the vaccine. With the vaccine course an arsenical is administered, usually at five-day intervals. We intend to treat all patients for a minimum of two years after subsidence of the active stage of the keratitis.

Local treatment in the acute stage consists of hot compresses to the eyes every two hours, and the instillation of a solution of atropin sulphate (usually 2 per cent)—two drops three times a day. As soon as all ciliary injection has disappeared, dionin is started. This is given by instillation of two drops of a 2 per cent solution twice a day for a week, increased to 5 per cent for a week, then 10 per cent for another week. Recently we have been using an insufflation of dionin powder once or twice a week for several weeks after the above series is completed.

All cases seen in the eye department are diagnosed on the basis of slit lamp and biomicroscopic examinations only. The progress and final result are made on the same basis, plus visual acuity with and without refraction.

REPORT ON CASES

There were thirteen acute cases. Of these, three were treated with typhoid-paratyphoid vaccine alone. Two of these three had a degree of activity not severe enough to justify malaria, and there was a satisfactory response to vaccine alone. The third had a severe bilateral interstitial keratitis. She was inoculated with malaria, but paroxysms did not appear, and we resorted to vaccine. The keratitis ran a stormy course, and although the patient received twenty satisfactory chills and fever plus arsenicals, the keratitis did not subside until the end of the third month. The keratitis has improved steadily, and the eyes are quiet at the end of the seventh month.

Ten of the acute cases had a satisfactory course of malaria, with immediate response of the keratitis after a few chills. Five of these remained quiet and improved over periods of one month to one year. One who had had a bilateral keratitis had completely clear corneas at the end of a year. Two had relapses six weeks and ten weeks after the end of the malarial course, but both responded to a few injections of typhoid-paratyphoid vaccine. One of these two had entirely clear corneas at the end of an eighteen-month period. Two had extension to the second eye without relapse in the previously affected eye, at the end of three-month and four-month periods, respectively, after malarial therapy. The acute keratitis subsided at once in both patients after five injections of typhoid-paratyphoid vaccine. One patient had both a relapse in the previously affected eye and extension to the second eye ten weeks after malaria. Continued administration of the arsenical, together with typhoid-paratyphoid vaccine, produced no subsidence of the interstitial keratitis in either eye during a one-month interval. We were unable to elicit satisfactory elevations of temperature with typhoid-paratyphoid vaccine in this patient. Because of previous success with malaria and at the patient's request, reinoculation with malaria was done five days ago.

Chronic Cases.—There were nine chronic cases. Three of these patients were treated with typhoid-paratyphoid vaccine alone. One of them was a four-year-old girl with bilateral interstitial keratitis of five months' duration. Eighteen months later the eyes were clear and no opacities were present. The second, a negress with a unilateral keratitis of six months' duration, failed to develop paroxysms after inoculation with malaria. Satisfactory chills and fever were not obtained with typhoid-paratyphoid vaccine, and the patient left the hospital against advice. Although the eye remained quiet, there was no regression of the opacities after four months of antisyphilitic treatment. The third, a case of bilateral interstitial keratitis of six months' duration, had an excellent response to typhoid-paratyphoid vaccine injections, although previous treatment with ten arsenicals had failed to produce any relief. One eye was entirely clear a year later, and the other showed a few small opacities.

Six of the chronic cases were treated with malaria. Four of these six cases were of five months to four years' duration. In all four the acute process subsided quickly, and there was a steady improvement in the keratitis. Of the remaining two cases, one was of eleven years' duration, and one of over five years' duration. Both had considerable scarring of the corneas. In both there had been some activity a short time before being seen by us. The former disappeared from observation one month after finishing his course of malaria, unimproved. The latter was still unimproved after six months in spite of continued antisyphilitic treatment.

COMMENT

The striking thing about the use of malaria is the rapid response of the keratitis. Photophobia, lacrimation and pain quickly subside after the first few paroxysms. Ciliary injection also is often gone by the end of the course of malaria, although it may persist for two to three weeks. By the end of the course of malaria, vision is often markedly improved, and infiltrations in the cornea are beginning to regress. All sixteen cases treated with malaria showed marked improvement, except the two patients with chronic interstitial keratitis of five and eleven years' duration, respectively. Although five patients suffered relapse or extension six weeks to three months after malarial therapy, four of them quickly responded to supplementary typhoid-paratyphoid injections. The fifth, as already mentioned, did not obtain satisfactory elevation of temperature from typhoid-paratyphoid injections, and was reinoculated with malaria.

It has occurred to us that, following the malarial therapy for acute cases, it might be wise to give the patients weekly injections of boiled milk for, possibly, two to three months in an attempt to prevent relapse.

Of the six patients who received only typhoid-paratyphoid injection with chemotherapy, two had been inoculated with malaria, but paroxysms did not appear. One of these two had a particularly severe interstitial keratitis, and response to the vaccine and chemotherapy was slow, requiring three months for subsidence of the acute stage. The other received no benefit from typhoid-paratyphoid vaccine, because of inadequate temperature elevation and a short course. The remaining four had a degree of activity which did not require malarial therapy; and although the response was slower than with such therapy, there was an ultimate satisfactory reaction to treatment.

It must be emphasized that the patients who received malarial therapy were suffering from a far more severe keratitis than those who received typhoid-paratyphoid vaccine alone, and that malarial therapy produced a much more rapid response to treatment than did the vaccine-plus-chemotherapy.

Although some of the patients have been under observation for only a few months, we believe that ultimately a satisfactory result will ensue in all of the cases treated, with the exception of the two mentioned above. Regression of the opacities and vascularization continue for a year or longer. It seems logical that the shorter time an acute process exists, the less scar tissue will form, and hence the less impairment of vision. At least, the remaining vision will stand a better chance of being restored to approximately normal with lenses. The above facts are self-evident if compared with statistics from the Los Angeles City Venereal Disease Clinic, where cases of interstitial keratitis are treated with the accepted type of chemotherapy only, and where it takes months for a case to become quiescent.* We intend to present a further report after a period of two years.

Certain points are noteworthy in this series. There were no cases of absolute blindness, nor were there any in which vision was reduced to light perception only. Most of the cases have 20/200 to 20/100 vision, and this, of course, can be improved with lenses. We have not been able to refract all of these cases because of difficulties in the way of social service. Furthermore, in cases with residual scars, it was not felt that it would be optically sound to give a rather strong myopic correction when the other eye was essentially normal, as there might be a tendency to aniseikonia. Then, too, patients in the younger age group (under eighteen) may obtain a good visual result such as 20/30 under atropin, but on postcycloplegic examinations this would be reduced to 20/100 because of central opacities and, with one normal eye, it was not deemed advisable to do an optical iridectomy on the affected eye; this latter procedure being resorted to in old, treated quiescent cases with bilateral involvement and markedly reduced visual acuity.

IN CONCLUSION

We believe that malarial therapy is a valuable addition to the therapeutic armamentarium in the treatment of both acute and chronic interstitial keratitis. Whether it will be a permanent addition depends on the results of treatment of new cases and the continued observation of previously treated cases over at least a two-year period.

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* Personal communication Dr. J. G. Kinney to the authors.

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DISCUSSION

Harold F. Whalman, M. D. (727 West Seventh Street, Los Angeles).—I have had the opportunity of seeing most of the cases which these authors have described and have examined many of them from time to time with the slit-lamp. As a result of this personal observation, I am impressed with the importance of heroic treatment of interstitial keratitis in its acute stage.

I have watched, for the past ten years, the treatment of a large number of cases of interstitial keratitis by the usual means of chemotherapy and gained the impression, as have many others, that there seems to be very little influence of such treatment on the course of interstitial keratitis.

From a pathological standpoint, interstitial keratitis may be described in four stages.

First, the stage of infiltration, characterized by the invasion of the cornea by spirochetes, resulting in an edema of the innermost layers of the substantia propria and swelling of the endothelial cells. Nodular areas form and become necrotic, and wandering cells begin to make their appearance.

In the second stage, this avascular vulnerable tissue becomes supplied with blood vessels which grow into the deeper layers first, gradually encroaching upon the center of the cornea, and later anastomosing with conjunctival arcades which have now invaded the middle or the anterior third of the cornea. These vessels are arranged in a rather characteristic palisade all around the cornea.

The cornea is now greatly thickened and the posterior layers are beginning to show considerable sclerosis, while great radial folds are noted in Descemet's membrane. This third stage is sometimes greatly prolonged.

Finally, following the more or less complete vascularization of the cornea and accumulation of the products of inflammation resulting in the thickening of the cornea, there is a stage of restoration in which destroyed tissue is replaced by scar, the blood vessels collapse and the cornea returns to approximately normal thickness. The blood vessels remain patent and fill with blood during any subsequent irritation of the eye. These vessels are pathognomonic of a previous attack of interstitial keratitis.

From the standpoint of preservation of vision, treatment of this condition must be efficacious during the first stage, and must put a prompt end to the cellular invasion taking place. Otherwise, in the later stages of sclerosis of the cornea, such opacification will result as to seriously impair vision.

Nonspecific therapy is the only treatment that has accomplished this important step. Harvey Howard, working in the great clinic of the Rockefeller Institute at the University of Peiping, made use of intravenous typhoid inoculations for this purpose in cases of interstitial keratitis as well as other kinds of ocular inflammation. A number of authors have substantiated this work, and a few cases with which I had early experience were reported in California and Western Medicine in December, 1931. This method, as the authors have pointed out, still has its place in the treatment of interstitial keratitis. However, their present report on the use of malaria as a nonspecific agent, indicates that its efficacy is very great and that it is a convenient and safe method of attacking a condition which may be so disastrous as to produce blindness.

I can confirm the authors' experience in receiving a negative Wassermann report at the beginning of many of these cases, so that it is important to be guided by accurate history and other clinical evidence. One such case in which vascularization was delayed until six weeks after onset, I mistook for a case of tuberculous keratitis. Tuberculin was administered without effect, and only after starting antiluetic treatment did the Wassermann return positive.

The authors are to be congratulated on presenting this important addition to the treatment of interstitial keratitis, and I am looking forward to hearing a further report from them as to the final visual results in an even larger series of cases.

William A. Boyce, M. D. (1210 Roosevelt Building, Los Angeles).—I have been very much interested in watching the results of the treatment of interstitial keratitis as outlined by Drs. C. Russell Anderson and Warren A. Wilson. I was fortunate in having the opportunity to see these cases before and after treatment, and the way they have responded to treatment has been most interesting and gratifying.

In the past it has been felt that every case of interstitial keratitis must run its course and that it was not influenced by constitutional treatment, and there was a certain percentage of corneas that were permanently damaged.

I consider that this treatment as outlined is a great advance in medical science, affording a ray of hope that we can pass on to our patients that something can be done to clear up these corneas rapidly and thereby give them more assurance of being able to preserve their vision.

I desire to congratulate Doctors Anderson and Wilson for their thoroughness and scientific manner in which they have attacked this problem.

THE LURE OF MEDICAL HISTORY†

TRUTH OVERTAKES "DOCTOR HUNTER"

By A. W. Meyer, M. D.
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PART II*

AUTHOR'S DISCUSSION

SINCE, as stated above, William said that Haller credited him with the "discovery" of the independence of the fetal and maternal circulations, in 1766, it seems all the stranger that this idea was not given explicit expression in the "Gravid Uterus," which appeared eight years later. It also is noteworthy that Haller did not adopt William's idea in the third edition of his *Primæ Lineæ,* in 1767, but maintained the idea expressed by him[self] in the edition of 1751, and found even in the German edition of 1788 and the English edition of 1801, in which one reads as follows: "This communication of fluids between the uterus and placenta seems to be demonstrated . . . lastly, from the passage of water, quicksilver, tallow, or wax, from the uterine arteries of the mother into the vessels of the placenta, as observed, and lately confirmed by eminent anatomists." (Pp. 437–38, Section 891.) Two eminent anatomists who thought that they had proved this, according to Fasbender, were Cowper (Bidloo's Anatomy, given out by Cowper at Oxford in 1697, in his own name) and Noortwyk (Uteri humani gravidi anatomia et historia, Lugd. Bat., 1743).[8]

In *A History of Embryology,* Needham[9] stated that Haller ". . . followed Noortwyck in asserting the separateness of the maternal and fœtal circulations in mammalia." However, as already intimated, William Hunter, Fasbender (1906) and

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† A Twenty-Five Years Ago column, made up of excerpts from the official journal of the California Medical Association of twenty-five years ago, is printed in each issue of California and Western Medicine. The column is one of the regular features of the Miscellany department, and its page number will be found on the front cover.

* Part I of this paper appeared in the issue of February, 1939, page 120.

[8] California and West. Med., Vol. 45, No. 6, p. 493, col. 1, par. 1, line 2 (Dec.), 1936.

[9] Needham, Joseph: A History of Embryology, p. 201. Cambridge, 1934.

Siebold[10] (1902) attributed the opposite view to Noortwyck[11] with respect to man. I regret that the original publication of Noortwyck is not accessible to me, but Fasbender quotes the following unambiguous words from it: *dubitari demum non posse de immediata communicatione vasorum uterinorum cum ovi vasis, quoniam materies, per ramum art. iliac. immissa, in vasa placentæ et chorii profunde penetraverat.*[12] (Immediate communication of the uterine vessels with the vessels of the ovum certainly cannot be doubted, inasmuch as material sent through a branch of the iliac artery penetrates deeply into the vessels of the placenta and the chorion.)

I fully realized that the above quotations from my brief articles did not and could not finally resolve the question at stake between the two brothers, but I have since come upon words written by William himself which do so with finality.

LETTERS OF WILLIAM AND JOHN HUNTER

In order to give full force to these words, it seems best to give, first, the letters written to the Royal Society by the Hunters. They are a matter of history and specifically call attention to the point at issue. It may be recalled that these letters were occasioned by John's contribution, of 1780, to that Society. William wrote to the secretary, apparently Paul Henry Maty, M.A., saying:

Windmill Street, Feb. 3, 1780.

Dr. Hunter begs the favour that the Secretary to the Royal Society will read to the Society what follows.

Mr. Hunter's account of the structure of the human placenta, explaining the connexion and circulation between the mother and fœtus in utero, which was read at the last meeting of the Royal Society, informs us that it was a discovery which he made with Dr. Mackenzie, and that it was not claimed by me. The Society will be sensible that I am reduced to the necessity of taking notice of this mistake, when they are informed of the following facts:

First. That the doctrine has been many years ago published in printed books as my discovery, and had been communicated as such by myself. See Baron Haller, for instance, in the second part of the eighth volume (p. 220) of his great Physiology in quarto, printed thirteen or fourteen years ago.

Secondly. Besides treating of it as my own discovery in my lectures on the subject, I have always done so, for many years past, in the very first lecture of my course, which is the most public of all, because the door is then open to every person whose curiosity prompts him to be present.

In the third place, occasionally in what I have printed, and in my lectures, I hope I have not overlooked opportunities of doing justice to Mr. Hunter's great merits, and of acknowledging that he had been an excellent assistant to me in this and in many other pursuits. By doing so, I always felt an inward gratification, shall I call it, or pride? I have given him all the little anatomical knowledge that I could communicate, and put him into the very best situation that I could, for becoming what this Society has, for some time, known him to be. May it be presumed then that I stand possessed of the discovery in question, till proofs shall be brought to dispossess me? I shall most willingly submit to the pleasure of the Society; if they signify an unwillingness that this emulation (shall I call it?) should go on, I shall acquiesce, and be silent. If curiosity, justice, or the laws and practice of the Society should incline the Council to seek out and determine upon the merits, I shall be equally ready to obey their commands. And if it should appear reasonable to them, I would first beg to know the grounds of Mr. Hunter's claim, as I am too well acquainted with his abilities not to think that he must be able to support his claim by something that I am ignorant of. And if I should receive that satisfaction, I shall immediately show that I am more tenacious of truth than even of anatomical discoveries. But if that information should not alter my thoughts on the question, I shall show to the satisfaction of the Society, if I can at all judge of my own employments and pursuits, that my pretensions arise out of a long series of observations and experiments made with a view to the discovery in question; that it was not a random conjecture, a lucky thought, or accidental occasion, but a persevering pursuit for twelve or thirteen years at least, the progress of which was always publicly known here, and admits of the most circumstantial proof.

William Hunter.[13]

* * *

John's response to William sent to the president of the same society, apparently Sir Joseph Banks, was as follows:

Jermyn Street, Feb. 17, 1780.

To the President of the Royal Society.

Sir,—Though I know the constitution of the Society over which you preside too well to suppose that they will give their judgment on any subject, and respect it too much to think it a proper field for waging the war of controversy, I cannot avoid requesting you to lay before that learned body a short answer to the paper given in by my brother, Dr. Hunter; as silence on my part, after his charge, may be interpreted by my enemies into an acknowledgment that I have intentionally claimed to myself a discovery in reality his due. I am as tenacious as he is of anatomical discovery, and, I flatter myself, as tenacious also of truth. The discovery was made in the manner in which I stated it in my paper. Dr. Mackenzie had injected the subject, and being unable, as I conceived, to explain an appearance which he had found in dissecting it, sent for me. I came to him, and having examined it further, explained the appearance in question, then, for the first time, to my own satisfaction and that of Dr. Mackenzie; and in the evening of the same day, full of the discovery, I came to Dr. Hunter, and brought him with me to Dr. Mackenzie, to see and judge of the explanation I had given and Dr. Mackenzie had agreed to. This is my state of the fact upon which I ground my belief of myself being the author of this anatomical discovery; but as my brother thinks differently, after a period of twenty-five years, I am content to abolish all remembrance of the successions of time in the course of that day, and to suppose that Dr. Mackenzie, Dr. Hunter, and myself inspected the parts together, and made the discovery, by which means the honour of it will be divided into three, one of which I may surely be allowed to take to myself, the other two may appertain to Dr. Mackenzie and Dr. Hunter, if they choose to claim, and be content with them; though in this division we must make some reserve for the claims of several ingenious young men, at that time pupils, who were with us, and of course entitled to some proportional share in the discovery, though their present situations, settled at a distance from this town, have prevented them from getting early notice of this present claim, and of course of making application to the Society for their share. However, I may here declare that if Dr. Hunter will produce to me any claim, which I can allow, of his having discovered this anatomical fact at any period of time prior to this conference at Dr. Mackenzie's, I shall first declare, in excuse for having troubled the Society, that I was not before acquainted with it, and immediately after declare that he is entitled to the sole honour of it, at least in preference to myself.

I am, Sir,

Your much obliged, and most obedient humble Servant,

John Hunter.[14]

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[10] Von Siebold, E. C. J.: Geschichte der Geburtshülfe, Zwei Bände. Tübingen, 1901.

[11] Noortwyck, W.: Uteri humani gravidi anatomia et historia. Lugd. Bat., 1743.

[12] Fasbender, Heinrich: Geschichte der Geburtshülfe, p. 414. Jena, 1906.

[13] Paget, Stephen: John Hunter, Man of Science and Surgeon (1728-1793). With introduction by Sir James Paget, pp. 70-73. London, 1897.

[14] *Ibid.*, pp. 73, 74.

COMMENT ON THE LETTERS

In regard to the first point in William's letter, it should be noted (1) that he mentioned no book in which his discovery was acknowledged except that of Haller, which contains no such acknowledgment, but refers instead to the page in William's *Medical Commentaries* containing a footnote in which the contrary opinion is vigorously defended; and (2) that he failed to say to whom he communicated his discovery unless he meant the public spoken of in "Secondly." This recalls to mind the comment of Paget, in the case of the quarrel between the Hunters and Pott, that William had recourse to rhetoric while John gave "a plain statement of all that he remembered."

Department of Anatomy.

(To be continued)

DEATH OF "DR. O. UPLAVICI"

By W. H. Manwaring
Stanford University

IN 1887 Dr. Jaroslav Hlava of Czechoslovakia reported the discovery of amebas in the stools and intestinal ulcers of patients suffering from dysentery, together with his success in transferring the disease to laboratory animals (cats) by intrarectal inoculation with human ameba-containing stools. His paper was published in the leading Czech medical journal of that day, under the title: "O uplavici; Predbezne sdeleni." ("On dysentery; a preliminary communication.")

By some unexplainable editorial oversight, Dr. Hlava's name was omitted in the German reviews of his paper. Credit for this basic medical discovery was, therefore, given to "Uplavici, O" (Dysentery, On).[1]

For fifty years international medical science paid homage to the mythical bacteriologist, "Dr. O. Uplavici," ranking him with Pasteur, Koch, and Lister, as one of the outstanding pioneers in modern medical science. It was not until a year ago that the mythical nature of this nineteenth century protozoölogist was recognized by Dr. Clifford Dobell of London, England, and a formal obituary of "Dr. O. Uplavici (1887-1938)" published in a leading English medical journal.[2]

While the creation and perpetuation of the "Uplavici" myth has probably neither hastened nor retarded the development of bacteriological science, Doctor Dobell's obituary may have a salutary effect on future medical historians. There are a number of other minor literary myths still honored in medical research literature, most of them of fairly recent Russian or oriental origin.

P. O. Box 51.

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[1] Centralbl. f. Bakt., 1: 537, 1887.
[2] Dobell, Clifford: Parasitology, 30: 239 (June), 1938.

Seldom shall we see in cities, courts, and rich families, where men live plentifully and eat and drink freely, that perfect health and athletic soundness and vigor of constitution which are commonly seen in the country, where nature is the cook and the necessity the caterer, and where they have no other doctor but the sun and fresh air.—South.

CLINICAL NOTES AND CASE REPORTS

CEREBRAL EDEMA

INJECTION OF AIR INTO THE SPINAL CANAL AS A THERAPEUTIC MEASURE

By George H. Sciaroni, M.D.
and
K. F. Sharp, M.D.
Fresno

PREVIOUS reports on the value of spinal puncture as a therapeutic measure in the treatment of cerebral edema have confined themselves to a discussion of the procedure as a means of decreasing intraspinal pressure by withdrawing small quantities of spinal fluid at certain intervals. This may or may not give the patient some relief from the distressing symptoms of increased intracranial pressure. We know that many cases of cerebral edema fail to show any appreciable increase in the pressure of the spinal fluid. This is particularly noticeable in some cases of epidemic encephalitis and brain concussion. Many of the varieties of encephalitis may fail to show increase in the pressure of the spinal fluid, as we have had occasion to observe in the patients we have seen in the San Joaquin Valley.

The usual method of treatment of these patients has limited itself, to some extent, to the use of hypertonic solutions of glucose, sucrose, magnesium sulphate, etc., intravenously. One of us, Dr. G. H. Sciaroni, has been using air injections into the spinal canal for a number of years as an important addition to the intravenous use of hypertonic solutions. The procedure he has used, and that we will describe here, demonstrates its value, not by decreasing spinal fluid pressure, but by deliberately increasing pressure within the cranial cavity. The patient is usually seated in an upright position, and a spinal puncture is done. No fluid is removed, but a small quantity of air, usually 20 to 50 cubic centimeters, is injected into the spinal canal, and this air rises to the cranial and ventricular cavities, where it exerts pressure on the brain, compressing the tissue and forcing the fluid out of the brain and into the blood vessels. Hypertonic glucose solution, 50 cubic centimeters of 50 per cent glucose, is usually given intravenously just preceding the spinal puncture, and we have noticed some unusually good results. Many of the patients treated in this manner were so seriously ill before air injections were begun that their prognosis was almost hopeless, and we have seen these patients make rapid and complete recoveries, showing improvement almost at once after air injection into the spinal canal was begun.

As we have mentioned, this form of treatment has been used for some time by Doctor Sciaroni, particularly during the spidemics of encephalitis in 1933 and 1934. His results were exceptionally good. We are reporting this more recent case of encephalitis because of many unusual features, the most remarkable of which was the rapid improvement shown by the patient as soon as air injections were started. His condition before that was extremely grave, and he made a rapid and continuous recovery as soon as air-injection treatment was instituted.

REPORT OF CASE

Mr. Ernest R., age 38, ranch laborer, married, father of five children. Past medical history essentially negative.

Present Illness.—The patient noticed some headaches for three days prior to admission to the hospital on August 6, 1938, but had continued working on his ranch because he did not consider the headache particularly significant. The night before his admission he developed a fever, but he did not know how much; he felt extremely weak and had rather severe pains in his back. A physician was consulted the next morning, as his illness continued to become worse, and he was sent to the hospital at once. His temperature on entrance was 104.6 degrees. He was acutely ill, semistuporous and irrational, and was troubled with frequent involuntary urinations. A negative Widal reaction ruled out the possibility of a typhoid infection. He had a leukocyte count of 13,400, 26 per cent of which were large lymphocytes, and urinalysis showed the findings negative except for a high degree of acidity. The patient was given a sedative and was started on a daily regimen of potassium citrate, 20 grains three times a day.

On the second day he was worse. He began having involuntary defecations as well as urinations, he was very drowsy and more irrational than on the previous day, and a spinal puncture was decided on for diagnostic purposes. The spinal fluid was under no increased pressure. The laboratory reported a white cell count of 229 per cubic millimeters of fluid, 96 per cent of which were young polymorphonuclear leukocytes. On the following day he was unable to take any food, he was more irrational, and had developed a tremor in both arms. His temperature did not go above 101.6 degrees during the dav. Treatment that day consisted of intravenous hypertonic glucose, 50 cubic centimeters of 50 per cent glucose, and some Hartmann's solution subcutaneously later in the day. On the fourth day after entrance he developed a severe quivering of the entire body, and was unable to swallow. His general condition became serious. The next day, the fifth after entrance, he was given 50 cubic centimeters of 50 per cent glucose, intravenously, and received his first air injection. A spinal puncture was done as soon as he had received the glucose, and the spinal fluid was seen to be under no great pressure. Without removing any spinal fluid, 20 cubic centimeters of air were injected. The patient made some improvement that day, and spent a more comfortable night. The entire procedure was repeated the next day, 20 cubic centimeters of air being injected a second time. Later, that same day, the patient's improvement was very noticeable. He began to eat liquid foods, became more rational, had a temperature less than 100 degrees all that day and night, and was less troubled by involuntary urinations. There were no involuntary defecations after that day. On the following day the procedure was repeated a third time, the patient getting 30 cubic centimeters of air into the spinal canal instead of 20 cubic centimeters as on the previous two days. He started to eat well, and ceased to void involuntarily.

On the following two days he received no air injections, and received no hypertonic intravenous solutions. He continued to show steady improvement and was eating a soft diet without difficulty. He suffered a relapse on the third day since discontinuing the air injections and the hypertonic glucose. He became irrational again, and had a return of his former symptom of involuntary passage of urine. His temperature rose to 102 degrees. On the following day there was a serious weakening of the pulse, and his condition became critical.

At that time another spinal puncture was decided on for the purpose of injecting air into the cranial and ventricular cavities. The patient was given 50 cubic centimeters of hypertonic glucose solution intravenously, and a spinal puncture was done. Without removing any fluid, 20 cubic centimeters of air were injected into the spinal canal. The patient showed improvement later that same day. He was more alert until late that night, when he became irrational again to a slight degree, and voided once involuntarily. He was noticeably better the next day, and continued to show improvement on each succeeding day. He had no more spinal punctures and no more hypertonic glucose solution after the single treatment given at the time of his relapse. He received no medication after that last injection, except some Epsom salts the second day. He was eating a general diet three days after the last spinal injection, and was sitting up in a chair after four days. He continued to make a steady uneventful recovery, and left the hospital three weeks after his admission. His subsequent history has shown almost complete recovery, and he has begun work on his ranch.

CONCLUSIONS

1. It is our opinion that a great number of patients having encephalitis who now die will recover if this treatment is properly pursued.
2. This suggests a new treatment for cerebral concussion, cerebral hemorrhage, etc.

1410 Pacific Southwest Building.

MIKULICZ'S DISEASE

A CASE REPORT

By Alfred C. Reed, M.D.
and
Francis Rochex, M.D.
San Francisco

In 1892 Mikulicz [1] described a clinical syndrome, characterized by a chronic, painless, uniform enlargement of the lacrimal and salivary glands in an individual with a normal blood picture. There was neither involvement of the lymph nodes nor of the spleen. Histologically the tissue resembled that of a lymphoma, in which the lymphoid hyperplasia lay between and compressed the secretory cells.

Some observers have noted that there may be no involvement of the lacrimal glands. Others have recorded the presence of exophthalmos associated with involvement of the lacrimal glands. There have been many and varied suggestions which have been offered regarding the possible etiologic factors. Favor has been given to the idea of a chronic infectious agent extending from the nasopharynx or operating from some distant focus. Many have stressed the importance of tuberculosis in the etiology, but the relationship has never been definitely established.

Mikulicz's syndrome is to be differentiated from atypical leukemia, chronic relapsing parotitis and simple hypertrophy of the glands. The glandular tissue often returns to its original size, following the administration of iodids or arsenicals. Roentgenotherapy is usually successful and surgery may be resorted to if other measures have proved ineffective.

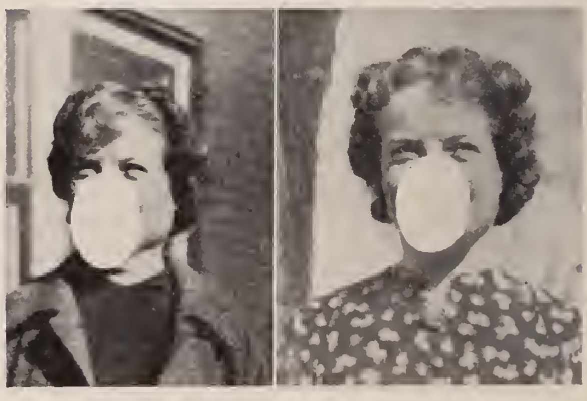

Fig. 1.—Before and after treatment.

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[1] Mikulicz, J.: Beitr. z. Chir. Festschr., 610, 1892.

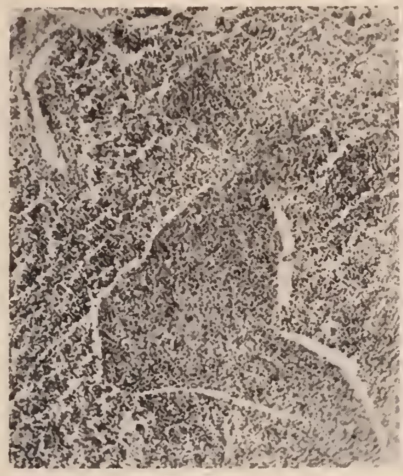

Fig. 2.—Parotid gland section, low power.

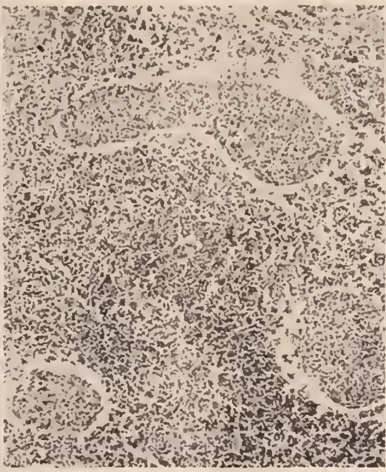

Fig. 3.—Parotid gland section, low power.

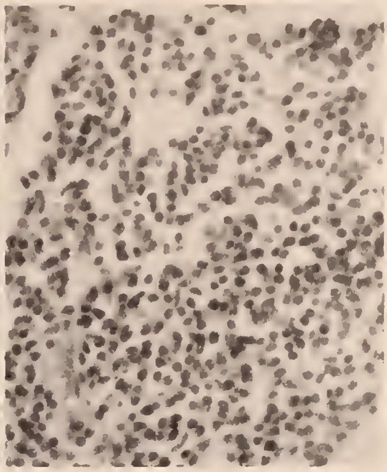

Fig. 4.—Parotid gland section, high power.

REPORT OF CASE

Mrs. H. A., age 35, was first seen by us on January 27, 1938.

Chief Complaint.—Swelling of the parotid glands bilaterally, which had begun with a severe head and chest cold three years before, and had been gradually enlarging since. She also complained of amebic dysentery, for which she had been under treatment for seven years past, recurring arthritis, and a tendency to anemia.

Past History.—She was born in northern California, went to Brazil in 1930, and returned to northern California in February, 1932.

Diseases: There were no hereditary diseases in the family. She had some of the minor childhood diseases only, and at one time had an enlarged liver, with jaundice. Tonsillectomy in 1922 was followed by severe hemorrhage. In 1929 her appendix was removed and internal hemorrhoids were cauterized. She was always troubled with constipation. Following this operation she was found to be anemic.

In 1930, a few days after her arrival in Brazil, she had her first attack of dysentery, which was diagnosed as ptomain poisoning. For the following year and a half she was treated almost continually for anemia.

In October, 1931, she became very ill, and Entameba histolytica was demonstrated in the stool. Treatment was with stovarsol. During her stay in Brazil her weight dropped from 116 to 96 pounds.

In February, 1932, she returned to California. During the following year she suffered from arthritis, neuritis, and amebic dysentery. She took many antiamebic drugs, but no emetin. Her stools were last positive for amebas in 1933.

In May, 1934, her arm swelled from elbow to wrist, but no diagnosis was made as to cause. Later that same year she had influenza, followed by colds which persisted all winter. In February, 1935, following a very severe head and chest cold, she first noted swelling of the parotid glands, which swellings has gradually increased to date. At no time has there been any pain or soreness in the glands.

From February, 1935, to January 27, 1938, when she first came under our observation, she received much medical treatment for anemia and amebiasis, and some medication for arthritis.

In December, 1935, her hemoglobin was 75 per cent, red blood cells 4,500,000, and leukocytes 11,850. In July, 1936, the hemoglobin was 58 per cent, and this varied from time to time to January 24, 1938, when it was 62 per cent.

During this time she states that she took, among other medicines, at least eight courses of carbarsone, extralin, lextron, haliver oil with viosterol, tabloid reduced iron, salicionyl, potassium iodid dicalcium phosphate, and yeast. She was nervous, lacking in energy, could not stand crowds, and was troubled with occasional arthritis. In July, 1936, she suffered from extreme dryness of the mouth and throat, which was eventually relieved by dilatation of the ducts of the parotid glands. An x-ray of the sinuses and parotid glands at this time showed no evidence of pathology.

Physical Examination.—Temperature, 99.4 degrees F. Teeth were in poor condition. There was bilateral, moderately marked, uniform, painless enlargement of the parotid glands. The thyroid gland was palpable and soft. The abdomen was tender in both lower quadrants.

Sigmoidoscopic examination showed redness and excoriation of the mucous membrane, which was thickened between the valves. Smears for aerobic and anaerobic cultures were taken from this area. No deep ulceration was noted.

Laboratory Tests:

Blood Count: Red blood cells, 4,310,000; hemoglobin, 79 per cent, Sahli (12.5 grams); color index, 92; leukocytes, 6,280; polymorphonuclears, 70 per cent; lymphocytes, 27 per cent; mononuclears, 2 per cent; eosinophils, 1 per cent.

There was slight anisocytosis and poikilocytosis. Red cells showed achromia. (On March 15, the red-cell count and hemoglobin had risen to normal.)

Urinalysis: PH 6.0; specific gravity, 1.018; albumin (—); sugar (—); rare pus cell; rare epithelial cell.

Basal metabolic rate: 7.2 per cent minus.

Eriometer reading: 7.9 micra.

Gastric analysis: (Alcohol test-meal.)

	Free HCl.	*Total Acid*
Fasting specimen 20 cc. Slight bile	0.	4.
Specimen I. No bile	0.	3.
Specimen II	0.	4.
Specimen III	0.	3.

Stools: Black color, normal odor. Formed, firm consistency. No food remnants. No mucus. Good digestion. Occult blood negative. Dominant bacteria mostly Gram-negative rods. Microscopic examination entirely negative. No parasites nor ova seen. (Series examined, including three specimens after saline laxative.)

Cultures: Taken by sigmoidoscope from upper rectal and lower sigmoid mucosa. Results were as follows:

(1) January 28, 1938:

Aerobic: No typhoid-dysentery organisms. Positive for a mixed culture of B. coli and a few Alpha hemolytic streptococci.

Anaerobic: Also showed a mixed culture of B. coli and an Alpha hemolytic streptococcus. Also, Bacterium necrophorum was isolated, using Dack's technique. This was lost in subcultures.

(2) March 24, 1938:

Aerobic: No typhoid-dysentery organisms. Positive for a mixed culture of B. coli, Staphylococcus albus and Corynebacterium flavidum.

Anaerobic: Positive for a mixed culture of B. coli, corynebacterium flavidum, an Alpha hemolytic streptococcus and a Gamma hemolytic streptococcus.

Wassermann: Reported negative by the patient.

Roentgen Examination.—X-ray of the gastro-intestinal tract, with special study of the small intestine, by Doctors Ingber and Rodenbaugh, gave the following result:

"Fluoroscopic examination of the chest; no abnormality.

"The stomach outlines are smooth, peristalsis is not increased, and there is no delay in emptying. The antrum is not spastic. The duodenal bulb fills readily, smooth in outline, and empties normally. The course of the duodenum is regular.

"Films taken at fifteen minutes, thirty minutes, one hour, two hours, four hours, and six hours show normal distribution of the meal through the small intestines, and no abnormality is noted.

"At six hours distribution is normal, the stomach being empty.

"At twenty-four hours barium is well distributed throughout the large bowel. The cecum has begun to empty, is movable and not tender."

Biopsy.—A biopsy of the left parotid gland was done by Dr. Frederick Foote under local anesthesia. His report is as follows:

"Grossly, this enlargement appeared to be of the gland itself, with the tissue thrown up in nodules. On cutting through it, the gland appeared to be particularly meaty, with small areas of cystic dilatation. These small cysts appeared to contain saliva."

The tissue was sent to Dr. Jesse L. Carr for examination. His report follows:

"Sections show an effuse replacement of the gland by large fields of lymphocytes between which are small islands of cells which are larger, more pale staining, and closely knit. Through this whole mass run dilated salivary ducts which are filled with granular blue coagulum. No normal gland remains.

"Pathologic diagnosis: Mikulicz's disease."

Diagnosis: Mikulicz's disease; chronic colitis; achylia.

Further Course.—X-ray treatment of the parotid glands was followed by rapid reduction in size to normal.

COMMENT

The question arises as to whether the bacterial colitis and achylia may have had an etiologic relation to the parotitis. The achylia may have predisposed to abnormal bacterial flora in the colon. The colonic bacteria, especially some of the streptococci, may have been involved. Of this we have no proof. The upper respiratory infections immediately preceding the parotid enlargement are apparently more closely related to the parotitis. Failing recovery of bacteria from biopsy material from the affected glands, the question of bacterial relations cannot be settled in this case, and we did not think of biopsy tissue culture until too late.

350 Post Street.

CATASTROPHIES FOLLOWING HEMORRHOID INJECTIONS*

By James W. Morgan, M.D.
San Francisco

The injection treatment for internal hemorrhoids, when bleeding at stool is the only symptom, is based on sound therapeutic principles. In selected cases the results are excellent. Injection may sometimes be used as a palliative measure when the hemorrhoids protrude through the anal orifice. The technique of injection is not easy and requires much practice. All this has been said hundreds of times, but no one seems to have called attention to the disastrous sequelae which often follow hemorrhoid injections.

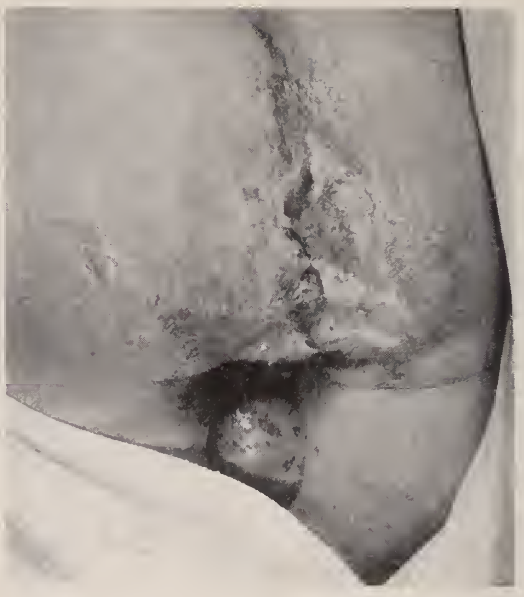

Fig. 1.—Photograph of the perineum of a male patient nineteen days after an injection treatment for internal hemorrhoids. The lower rectum and anus have sloughed away. The patient now has four anal orifices, with no control of bowels or bladder. This patient won a large award in a malpractice suit, but he has lost his rectum.

Gabriel reports a case of a patient with tubular stricture necessitating colostomy as a sequel to an injection treatment. Some rectal surgeons are opposed to any injections, and I predict that in the future we shall all use this treatment less frequently and with much greater discrimination.

The following is a summarized list of the more severe complications in patients who have come under my care following injection treatments:

A. Slough (chemical necrosis):
   1. Localized necrosis causing pain, but unattended by other sequelae.
   2. Generalized necrosis resulting in:
      (a) Mechanical hemorrhoidectomy.
      (b) Cellulitis, with sloughing of entire rectum and complete loss of control.
      (c) Septicemia.

B. Abscess (requiring surgical treatment):
   1. Local abscess.
   2. Anorectal fistula.
   3. Abscess terminating in chronic ulcerative proctitis and colitis.

C. Injury to contiguous structures:
   1. Rectovaginal fistula.
   2. Periprostatic abscess.
   3. Epididymitis.
   4. Vesiculitis with urethral hemorrhage.

D. Severe secondary hemorrhage.

I do not advocate hemorrhoidectomy in all patients with internal hemorrhoids. This operation is attended by some slight risk, and the patient needs to be away from his work for two weeks. The operation offers, however, the only cure, and injection treatments might do more harm than good.

384 Post Street.

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* From the Department of Surgery, University of California Hospital.

BEDSIDE MEDICINE FOR BEDSIDE DOCTORS

An Open Forum for brief discussions of the workaday problems of the bedside doctor. Suggestions of subjects for discussions invited.

PYELITIS IN CHILDREN AND INFANTS

I. ETIOLOGY

Hartzell Harrison Ray, M. D. (23 Second Avenue, San Mateo).—Pyogenic infections of the urinary passages are manifested by pus in the urine coming from the kidney, the pelvis of the kidney, the ureters, bladder or urethra. In clinical pediatrics this condition has most frequently been called pyelitis.

Pyelitis occurs in children of all ages, and is estimated to constitute about one per cent of all illness seen in pediatric practice.[1] It is twice as common under two years of age as after that age.[2] It may occur in the first week of life, and is more common in boys.[1] Conrad[3] examined the urine of 190 consecutive newborn children and found that 39 had pus. Of these, 15 children had 15 to 20 cells per high dry field, 15 children had 20 to 60 cells, and 9 had 100 or more cells per high dry field. He was able to examine fourteen of his thirty-nine cases two years later and found only one that showed any pus. The finding of pus in the urine of newborns may not represent pathology, however, for it may be due to anuria or initial dehydration.

In infants as many boys as girls have pyelitis, while in older children it occurs three or four times as frequently in females as in males.[2] There is a very slight seasonal variation, pyelitis being seen more frequently during the seasons when gastrointestinal disorders and upper respiratory infections are present. The incidence of pyuria will also vary in different epidemics of gastro-intestinal and upper respiratory infections.

The presence of congenital abnormalities in the urinary tract are often the direct or indirect cause of pyelitis. This is especialy true in chronic pyelitis.[4] Those congenital abnormalities that prevent proper drainage of the urinary tract, or produce stasis, result more often in pyelitis. Hurt[5] found urinary tract abnormalities in 5 per cent of newborns that came to autopsy. Bugbee and Wollstein[6] reported that approximately 2.5 per cent of necropsies on children revealed congenital anomalies of the urinary tract. In a series of 2,420 autopsies, Campbell[7] demonstrated that 2 per cent of children had some degree of ureteral blockage, and one-half of these were types of ureteral stricture. Not all congenital abnormalities of the urinary tract are accompanied by pyuria; they may be only potential causes. Congenital fibrosis, kinking or stricture of the ureters, polycystic kidneys, double ureter, horseshoe kidney, muscular hypertrophy or atony of the ureters, or congenital narrowing of the caliber of the urinary tract chiefly at the point of normal anatomic narrowing, the uretero-pelvic, ureterovesical and vesical outlet, can cause pyelitis. At times there appears to be a neurogenic dysfunction or neuromuscular disturbance at the ureterovesical junction which can produce stasis and subsequent pyuria. Occasionally, pyelitis is seen where neurological lesions, either central or peripheral, involve the bladder, such as poliomyelitis, cerebrospinal syphilis, spina bifida and toxic neuritis.[8] Renal calculi, renal tumors, tuberculosis of the urinary tract, suppurative processes in or about the kidney, or tumors that press upon and obstruct the urinary passages can cause pus in the urine.

Dyes, foods, drugs, alcoholic drinks, chemicals, heavy metals and substances that cause irritation when they reach the urinary tract, can be followed by pus in the urine. Allergy may play some part in these reactions or may be a primary cause in some cases.

In clinical pediatrics one is impressed with the frequency of pyelitis occurring in girls who have or have recently recovered from upper respiratory infections. The pus in the urine may be found for a few days or longer. Tonsillitis, sinus disease, mastoiditis, and the acute exanthemata are frequently accompanied or followed by urinary findings.[9] Dental caries may also produce pyelitis.[10] Occasionally, one sees a patient whose urine was negative before tonsillectomy flare-up, with a transient pyuria afterward without other demonstrable urinary disease. Such findings have suggested to some that possibly focal infections play an important part in the production of pyuria. The pyelitis may represent a toxic reaction, an allergic reaction, or possibly a reaction to a filterable virus.[11]

There are many cases of pyelitis where no causative factor can be found. Pus may appear in the urine without any other clinical evidence of disease and disappear as it came.

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[1] "Clinical Pediatrics—Genito-Urinary System." Vol. 19. Helmholz and Amberg. Pp. 139.

[2] "The Diseases of Infants and Children." 1937. Griffith and Mitchell. Pp. 807.

[3] Conrad, Charles E.: Urinary Findings in the Newborn, South. M. J., Vol. 31, No. 6, p. 636 (June), 1938.

[4] Summerfeldt, Paul, and Brown, Alan.: A Study of Forty Cases of Persistent Pyuria, J. Pediat., 5:727 (Dec.), 1934.

[5] Hurt, A. S.: Anomalies of Urinary Tract in Infants, Am. J. Dis. Child., 38:1202-1205 (Dec.), 1929.

[6] Bugbee, Henry G., and Wollstein: Infections of the Urinary Tract in Children," New York State J. Med., 25: 1063–1065 (Dec.), 1925.

[7] Campbell, Meredith F.: Congenital Bilateral Ureterovesical Junction Stricture in Infants and Children, J. Urol., 26:529 (Oct.), 1931.

[8] Hepler, Alexander B.: Nonobstructive Dilatations of Upper Urinary Tract in Children, J. A. M. A., 109:1602–1606 (Nov. 13), 1937.

[9] Cross, W. W.: A Study of Four Hundred and Seventy Cases of Urinary Tract Infection, The Urol. and Cutan. Rev., p. 703 (Oct.), 1937.

[10] Rosenow, E. C., and Meissner, J. G.: Elective Localization of Bacteria Following Various Methods of Inoculation and the Production of Nephritis by Devitalization and Infection of Teeth in Dogs, J. Lab. and Clin. Med., 7:707–722 (Sept.), 1922.

[11] Cook, Edw. N.: Urinary Infections, M. Clin. North America, 21:797 (May), 1937.

Whatever the anatomical or focal cause for pyelitis may be, the active agents in most cases where inflammation of the urinary tract is present are bacteria. There are three possible routes for bacteria to gain access to the urinary tract: (*a*) by ascending from the urethra, (*b*) by the blood stream, and (*c*) by the anastomosing lymphatics. It has been held that the cocci, with the exception of the streptococcus fecalis,[12] probably reach the urinary tract by way of the blood stream. The bacilli generally represent the ascending infection from the urethra and thus explain the greater frequency of this type of infection in the female. Whichever organism is found may not be the causative agent, according to some reports, but only a secondary invader. Bacillary infections are by far the more common, being found alone or in combination in 60 to 80 per cent of cases.[2] Hellstrom,[13] in his series, had an almost equal number of males and females with coccal infections, and in the same series for bacillary infections there were 13 males and 120 females. Helmholz,[12] in children under fifteen years of age, had an equal number of boys and girls with coccal infections, while with bacillary infections 85 per cent of the infants were girls, and in older children 75 per cent were girls. It may be a point for argument that since coccal infections are equal in the two sexes and bacillary infections more prevalent in girls that the route of invasion of the two organisms is different.

The more common types of organisms found in pyelitis are Escherichia coli, Aërobacter aërogenes, Proteus ammoniæ, Pseudomonas, Salmonella, Alcaligenes, typhoid, Shigella, Streptococcus fecalis, Streptococcus (green-producing), Streptococcus hemolyticus, Staphylococcus, gonorrhoeae, and tuberculosis.

* * *

II. DIAGNOSIS

William E. Stevens, M.D. (490 Post Street, San Francisco).—In the presence of fever of unknown origin during infancy and childhood, pyelitis (pyelonephritis) should always be suspected and a catheterized specimen of urine be carefully examined. Pus in an acid urine is due to pyelitis in the majority of these patients. In female infants and children it is the most common pathological condition of the urinary tract. Cultures are imperative. They will usually reveal colon bacilli, although cocci are not uncommon. If pus, blood or bacteria are found in the catheterized specimen of urine, a thorough urologic examination is demanded in order to determine its source since, during infancy, pyuria or hematuria is often the only symptom pointing to the genito-urinary tract. The importance of early diagnosis of kidney infections cannot be overemphasized because, if allowed to become chronic, many of these conditions are difficult and, at times, impossible to cure. Pyelitis may persist indefinitely, however, with few, if any, symptoms. Other cases progress more rapidly and, if untreated, result in destruction of the kidney. During infancy it is a self-limited disease in 50 per cent of cases. Some abnormality of the urinary tract will be found in about one-third of the remainder. I believe that pyelitis occurring during pregnancy is occasionally an exacerbation of a low-grade infection that has persisted since infancy.

Pyelitis occurred in almost one-third of our series, 74 of 205 cases, with urinary-tract pathology, and was found about four and one-half times as often in females as in males. This corresponds to the majority of the statistics reported in the literature. Pus, pus casts, and a few red blood cells are usually found in the urine, while chills, fever, frequent urination, dysuria, gastro-intestinal disturbances and prostration are the most common subjective symptoms of this condition. In children over two years of age, tenderness in the kidney region is often detected on palpation.

Pyelitis is to be differentiated from such conditions as acute intestinal infections, acute glomerulonephritis, tuberculosis of the kidney and calculi. The continuation of fever after the intestinal intoxication is relieved, and the positive urinary findings, suggest pyelitis. The polynuclear leukocytosis is lower than in appendicitis. Phenolsulphonephthalein output is decreased in severe renal infection. As in the adult, negative cultures in the presence of pus are suggestive of tuberculosis. In glomerulonephritis casts, more albumen, a larger number of blood cells and fewer pus cells will be found in the urine. Most calculi will be detected by roentgenography. This procedure will also often reveal some irregularity and dilatation of the kidney pelvis and calices in chronic pyelitis.

The determination of the presence or absence of stasis is of great importance. Functional kidney tests, urethral and ureteral calibration and pyeloureterography are indicated when this is suspected as well as in those cases that do not improve in ten days or two weeks under conservative treatment. The frequency of anomalies of the urinary tract as primary or contributory factors is of importance from the standpoint of diagnosis as well as of treatment of pyelitis during infancy and childhood.

It is only within a comparatively recent period that the value and practicability of modern diagnostic urologic procedures during infancy and childhood have been appreciated. It is now possible to procure satisfactory cystoscopes of such small size that age is no longer a contraindication to cystoscopy, cystography, catheterization of the ureters, chromo-ureteroscopy, comparative functional kidney tests or retrograde pyelography. There is, as a rule, comparatively little reaction following instrumentation in infants and children. Gentleness is, of course, essential. The fact that in these patients the bladder and, consequently, the ureteral orifices are at a higher level in the pelvis, should be remembered. The intravenous or intramuscular injection of indigocarmin will be helpful when visualization of the ureteral orifice is difficult because of injection of the bladder mucosa or for other reasons.

It is usually necessary to employ general anesthesia in children under ten, although I have occasionally been able to cystoscope and catheterize the ureters of patients as young as six years of age following the application of a 5 per cent cocain solution to the urethra on a cotton-tipped applicator. Corbus advises the hypodermatic injection of one-ninth to one-third of a grain of pantopon, one-half hour before cystoscopy, and the application or injection of a 0.5 per cent cocain and sodium bicarbonate solution to the urethra. The administration of fluids prior to cystoscopy is important.

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[12] Helmholz, Henry F.: Ascending Infections of the Urinary Passages, Am. J. Surg., 38:18–27 (Oct.), 1937.

[13] Hellstrom, John: Beitrag zur Kenntnis der Staphylokokken Pyelitis besonders in ihrere chronischen Form und über eine bei derselben vorkommende ergenartige Konkrementbildung, Acta. chir. Scandinav. Suppl., 4-6:1-280, 1923-1934.

A smaller quantity of urine is excreted by children's kidneys during general anesthesia, and a temporary reflex anuria has not been uncommon in my experience. Haines and Milliken have recently shown that ether anesthesia inhibits kidney function, both the quantity of urine and the elimination of dyes being decreased. They believe this to be due to constriction of the renal vessels. The preliminary injection of morphin and atropin, however, partly prevents the constriction, and to a certain extent the decrease in kidney function. There is apparently somewhat less interference with renal function during the administration of nitrous oxid and oxygen. Spasmodic contractions of the bladder occasionally interfere with rapid catheterization of the ureters in infants if anesthesia is not complete. In addition to temporary inhibition of function, the small size of the catheters, necessarily used in some of these patients, is often a contributing factor to the occasional difficulty of performing satisfactory functional kidney tests and of obtaining a sufficient quantity of urine for proper examination. These facts should be taken into consideration when ureteral catheterization and functional kidney tests under general anesthesia are contemplated.

* * *

III. TREATMENT

E. **Earl Moody**, M. D. (829 South Alvarado Street, Los Angeles).—In a great majority of cases the treatment of pyuria in infants and children is a most satisfactory procedure. Early satisfactory results with simple methods are usual. However, some cases are intractable to treatment and try the patience of the physician, and the long duration of symptoms is discouraging to the parents and the patient as well. It is these cases that do not respond well which demand of the physician a thorough knowledge of the pathology present and the type of bacteria causing the infection, as well as a familiarity with the therapeutic measures available.

Children suffering with pyuria are usually acutely ill with severe toxemia and high temperature. They should be treated like other acutely ill children. Absolute bed rest is essential. The environment should be pleasant, with ample light and air. Chilling should be avoided. Nursing care should be efficient.

As with any acute infection, we feel that an adequate intake of fluids is the first thought of the physician. The child must be assured of 150 to 200 cubic centimeters of fluid per kilogram of body weight, each twenty-four hours during the acute stage. This will prevent and cure dehydration. It will dilute toxins, and will flush the kidneys and urinary tract of bacteria with their toxins. This procedure alone often lessens symptoms to a marked degree. Most children will take enough fluid by mouth without resorting to other means of administration. Plain water is very acceptable. Fruit juices will be well tolerated and enjoyed, and are valuable in shifting the urine toward the alkaline side. Skim milk, buttermilk, or lactic-acid milk will supply food as well as increase the total fluid intake. To sweeten the fruit juices and water with karo, honey, or sugar will often increase the desire of the child to take fluids, and will, at the same time, furnish a high carbohydrate intake, thereby supplying food as well as preventing and curing an acidosis. It must be remembered, however, that some children object to the constant sweet intake, and one will get faster results if he will restrict himself at these times to plain water for a few hours. We feel that any treatment which demands withholding of fluids in these acutely ill children has no place in pediatric practice. Most of these cases will be treated in the home. It is imperative that the physician definitely outline to the parents the minimum amount of fluid required for each twenty-four hours, and that the amount should be accurately measured.

If the child does not take kindly to an adequate intake of fluids, giving 5 to 10 cubic centimeters with the medicine dropper every few minutes will often prove a successful method of administration, especially with the small infant. If this does not allow the minimum intake, then other methods of administration must be followed. Fluids can be administered by gavage, subcutaneously, intraperitoneally or intravenously. Acutely ill, dehydrated, small infants may not absorb subcutaneous fluids well and severe edema may result temporarily. This is no distinct disadvantage except that it is an indication the fluid given is not being utilized, and other methods of administration must be followed. Except in a badly distended abdomen, the intraperitoneal route offers a method of administration that is simpler than the intravenous, and for this infection is equally as effective and as safe. Large amounts of normal saline can be given by this method without discomfort or harm. Excessive intra-abdominal pressure is to be avoided. There is no objection to any of these extra-oral methods of fluid administration, but they are uncomfortable or painful to the patient. Patience and perseverance on the part of the nurse, in mouth administration, often will save this discomfort. In administering this life-saving and curative fluid, however, the rest of the patient must not be neglected, and ofttimes more rapid methods, which will allow greater rest, hasten recovery.

The judicious use of alkalies in the treatment of pyuria has won for itself a well-deserved place in our therapeutic attack. Even though it has been shown experimentally that the P^H of the urine must be as high as 9.2 before it can affect the bacteria present, and that, with large doses of alkalies, a P^H beyond 8.4 is never reached, yet, from practical experience we know that the use of large amounts of fluids with alkalies takes care of the great majority of cases in a few days. With some physicians this is the method of first choice. One should give the equivalent of seven and one-half grains each of sodium bicarbonate and sodium citrate four times daily to small children, and double this amount to older ones. The action of the alkalies is not definitely understood. It has been suggested that the good results are due to the diuretic action, the direct effect upon the tissues or even a bacteriophage reaction. But the method works in a high percentage of cases and is the simplest of all procedures, and should, in our opinion, be the first method of attack.

The acidification of the urine has long been a standard method of treatment. Sodium acid phosphate and benzoic acid are not now commonly used and have been replaced by such salts as ammonium chlorid, ammonium nitrate, calcium chlorid and sodium and ammonium mandelate. These salts, in adequate dosage, lower the P^H of the urine to the level of 5.5 to 4.8, where bacterial growth is inhibited. This degree of acidity must be tested by some indicator, and sufficient drug used to keep the P^H below 5.5. If a strip of chlorophenol red paper remains yellow when dipped in the urine, this state has been reached. Such a condition is brought about by giving 0.5 gram of the acid salts every four hours to the smaller children, and larger doses to older children. If pus, bacteria, and febrile symptoms do not disappear in a few days, the addition of methamin may be tried. Less of this drug will be required if the urine is held in a highly acid state. An infant should receive 0.2 gram four to six times daily. In hospital practice, culture of the urine should determine whether the treatment has rendered the urine free of bacteria. In bedside practice it is practical to continue the treatment a few days after all symptoms have subsided and the urine is microscopically free of all pus cells. Such a procedure usually guarantees that there will be no return of the symptoms.

If results are not rapidly obtained with either of the above methods, brilliant results are sometimes secured when the urine is rapidly changed from a strongly alkaline to a strongly acid reaction. This process can be repeated several times in succession. It has stood the test of time because of the results obtained.

It has been interesting to observe the evolution of the process of acidification of the urine. We are indebted to Dr. Henry Helmholz of the Mayo Foundation for much of our knowledge in this respect. After the limitations of the use of the acid salts with methamin were demonstrated in certain cases, the ketogenic diet was used to insure the P^H as being sufficiently low to be bactericidal to organisms. The use of this procedure is very limited. It can be followed out only under rigid control, and then used only in the older children in the chronic stage of infection. It is utterly impossible to use such a procedure in the acutely ill patient. Acidosis would be increased, which would produce severe vomiting, thus further increasing dehydration, which often is seen in these cases. With appetite already markedly reduced in these acutely ill patients, it is next to impossible to get them to take such a diet. Theoretically, it is possible. Practically, it has no place in "bedside medicine."

In the past few years the use of Mandelic acid has been common. This is given in the form of the sodium or ammonium salt, and is excreted unchanged in the urine. It is usually dispensed in the form of a 40 per cent syrup of the ammonium salt.

When the acid salts are given, occasionally nausea and vomiting result, and even blood may appear in the urine. The value, we feel, lies not in the acute condition, but in the more chronic state where the individual has developed some immunity to his infection and is not overwhelmed with acute toxemia. We have seen many acutely ill children made more so by such treatment instituted early in the course of the disease.

It seems that sulphanilamid will also have its day in the treatment of urinary infections. It has been shown to be very effective in all bacterial infections of the urinary tract, except that due to Streptococcus fecalis. It is effective in low concentration and works best in an alkaline urine. It can be given in the acute stage together with the usual forced intake of fluids and urinary alkalinization. Even in cases of reduced renal function it is valuable. The drug is eliminated through the kidney, and because the concentration needed in the urine is not high, sufficient quantity of the drug will be excreted by the damaged kidney to render the urine bactericidal. Experimental work has shown that a concentration as high as 100 milligrams per cent can be maintained by such small doses as 25 grains per day. Such concentration, it seems, is not necessary for successful treatment of urinary infection. Some feel that, for the usual infections, a concentration as low as 15 milligrams per cent is effective. As added experience is gained, the relationship of dosage to urinary reaction will be effectively worked out. Already we know that the dosage need not be large in urinary infections. Such daily dosage as five to seven grains for infants, seven to fifteen grains for children of from two to three years, and the upper limit of thirty grains for the older children, is effective. It is possible that, when our knowledge is complete, this method of treatment of urinary infection will supplant all others. Until that time the physician must choose from the rather wide armamentarium that procedure which seems to fit the individual case best.

The diagnosis of pyelitis is not complete as long as abnormalities of the urinary tract are not excluded. The occurrence of such abnormalities are not high in proportion to the total number of cases of pyuria seen. The great majority of the cases will respond to one of the methods of treatment outlined above in a relatively short time. A certain few will not. Then it must be determined by urological methods whether an abnormality does exist, for all of the above treatment will be of no permanent benefit until such abnormalities are corrected. We feel that any pyuria that does not clear in a period of four to six weeks should have the benefit of urological consultation. We would take strong issue with some of our urological consultants who feel that all cases of pyuria should be instrumentated early, and this during the acute stage of the disease. It is pathetic to see the severe reactions that sometimes result from such procedures. Our results are so gratifying in a few short days, by simple treatment in such a high percentage of cases, it would seem that common sense would dictate the use of the simplest procedures first. Certainly, no great harm can come in the average case because of a delay of a few weeks in correcting an abnormality which has existed throughout life. The physician, however, should never allow himself to be found guilty of neglecting to have urological consultation if the means at his disposal do not bring results in a few short weeks. Pyuria appearing in the very young infant, however, demands earlier investigation than the ordinary cases, for here abnormalities somewhere in the urinary tract are much more apt to be the etiological factor.

It would seem self-evident that if a known focus of infection were the etiological factor in the pyuric condition, such focus should be removed when the state of the child warrants such a procedure.

Summary.—A rational summary of our armamentarium in the treatment of pyuria in infants and children would be as follows:

1. Bed rest under proper environment.
2. Adequate intake of fluids, with alkalinization of the urine as the first step.
3. The acidification of the urine by the method most suitable to the case in hand.
4. The use of sulphanilamid under proper control. Perhaps this procedure will eventually take first place in our attack.
5. Urological consultation for the case that does not respond well to these measures.
6. The removal of foci of infection.

Drug Treatment in Coronary Disease.—Drugs have practically no value as a specific treatment for coronary disease if the patient is free of symptoms, Harry Gold, M.D., New York, declares in *The Journal of the American Medical Association* for January 7. The one exception is syphilis involving the blood vessels of the heart.

At the present time there are no drugs that definitely influence the course of disease of the muscles and blood vessels of the heart. However, when pain exists certain drugs are beneficial.

The nitrites are the preferred drugs in the treatment of effort angina (pain on effort). The nitrites do not impair awareness of pain but abolish the mechanism that causes it.

The nitrites are not entirely free of disagreeable effects. They may bring about such minor symptoms as flushing of the face, headache, a sensation of throbbing and tension in the head, palpitation and, in excessive doses, collapse. Sometimes these symptoms can be averted by reducing the dose without losing the effect of the drug.

The dose should be taken at the first suggestion of the oncoming pain. Some patients, guided by a mistaken notion that danger of injury or the development of habit is involved in frequent use of the nitrites, wait for the full development of pain.

The frequent use of the nitrites will neither lead to dependence on them nor reduce their efficacy.

Of the numerous other drugs used in heart disease, the xanthin compounds exert no action that is useful for the routine treatment of heart pain.

The purin bases are extremely valuable in promoting the secretion of urine in congestive heart failure.

In a typical case of coronary thrombosis in which there is agonizing pain, anguish and terror of impending death, morphin is the preferred drug. It not only relieves pain but also abolishes the desire to move about and in many instances gives rise to a sense of well-being which is quite apart from its analgesic effects.

By reducing nervous excitability the barbiturates decrease the number and severity of the attacks of effort angina. By means of the barbiturates fear, anxiety and restlessness in acute coronary thrombosis may be controlled.

Digitalis is useful in heart failure and in certain disorders of heart rhythm.

The indications for drugs promoting the secretion of urine include in part those for digitalis. These drugs are useful for the control of congestive heart failure and attacks of recurrent labored breathing.

While in many instances great suffering is spared and a life is saved through the judicious use of these many drugs, the major part in the control of this disease lies not in drugs but in expert guidance in making the mental and physical adjustments which will enable these patients to carry on within their capacity without symptoms of heart disease.

Almost Any of Mankind's Diseases May Be Cause of Failing Vision.—Failing vision may be due not alone to the eyes themselves but to any one of the many diseases of mankind, Samuel I. Kaufman, M.D., Chicago, declares in the February issue of *Hygeia*.

Although most cases of failing vision result from faulty shape of the eyeball and can be corrected only by glasses, those cases due to disease must be given medical or surgical treatment. The eye physician, therefore, must be properly trained in the relationships between the eye and the rest of the body, as well as in the structure and function of the eye itself.

"Any one of the many diseases that afflict the human body as a whole may cause failing vision," Doctor Kaufman says. For example, the retina may be affected by Bright's disease, diabetes, syphilis, high blood pressure or arteriosclerosis.

"Abnormal changes of the retina may take the form of hemorrhage, swelling, scarring, degeneration, atrophy or even detachment of the retina itself from its underlying structures," he points out.

Brain tumors, syphilis, sinus infections and chronic poisoning from lead, wood, alcohol or tobacco are among the diseases which may damage the optic nerves.

Glaucoma or hardening of the eyeballs, a frequent cause of blindness, gives no warning of its presence. The best chance for a cure of this disease lies in its early recognition and prompt treatment.

Double vision, caused by paralysis of the ocular muscles, is generally "a manifestation of some deeply seated disease and calls for the most painstaking investigation to determine its exact nature."

"By far the most frequent cause of this disturbance is advanced syphilis," says Doctor Kaufman. "Other less frequent causes are multiple sclerosis, brain or orbital tumors, inflammation of the nasal sinuses, ear infections, diphtheria, diabetes, poisons and injuries."

If no disease is present and glasses are prescribed, the patient should heed the physician's advice to have the glasses made at a reputable optical house.

"No matter how accurately the prescription for glasses is arrived at, it frequently fails to give the best results in improved vision and comfort because of defective materials and workmanship used in making the glasses," the author warns.

The calamity of blindness is now rare, Doctor Kaufman says, "largely because of the untiring efforts of some courageous workers in convincing reluctant legislators to enact the so-called 'Silver Nitrate Law,' which effectively prevents eye infections in the new-born.

"Similarly, cases of blindness resulting from industrial eye injuries, which were once so frequent, have now been largely brought under control in the larger industrial plants through adoption of various safety measures.

"It is within the range of possibilities that a pure food and drug act may yet effectively protect the public against dangerous poisons injurious to sight, which are contained in various commercial preparations advertised for such things as reducing weight, removing superfluous hair and dyeing hair."

CALIFORNIA MEDICAL ASSOCIATION

This department contains official notices, reports of county society proceedings and other information having to do with the State Association and its component county societies. The copy for the department is submitted by the State Association Secretary, to whom communications for this department should be sent. Rosters of State Association officers and committees and of component county societies and affiliated organizations, are printed in the front advertising section on pages 2, 4 and 6.

CALIFORNIA MEDICAL ASSOCIATION†

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CHARLES A. DUKES	President-Elect
LOWELL S. GOIN	Speaker
KARL L. SCHAUPP	Council Chairman
GEORGE H. KRESS	Secretary-Treasurer

OFFICIAL BUSINESS

ASSOCIATION ACTIVITIES

1. *California Physicians' Service.*
2. *Postgraduate Conferences.*
3. *Executive Committee.*
4. *Midyear Conference of California Medical Association Officers and County Society Secretaries.*
5. *Senate Bill 1128: Compulsory Health Insurance Bill.*
6. *Automobile Court Rates: Del Monte Annual Session.*

DEPARTMENT OF PUBLIC RELATIONS

1. *California Legislature: Summary of Public Health and Similar Bills.*
2. *California Legislature: Names of State Senators and Assemblymen.*
3. *Committee on Pneumonia Control.*
4. *California Tuberculosis Association.*

CALIFORNIA PHYSICIANS' SERVICE*

The letter which appears below gives information that should be of interest to all who have been interested in the development of the medical service plans of the California Medical Association. Every California Medical Association member should take the time to read it and to govern himself accordingly.

(Copy)

San Francisco, February 14, 1939.

To Administrative Members,
California Physicians' Service.

Gentlemen:

The trustees have held two day-long meetings in San Francisco. The Articles of Incorporation were filed with the Secretary of State on February 2, 1939, and the trustees elected the following officers on February 4, 1939: President, Ray Lyman Wilbur; vice-president, Lowell S. Goin; vice-president, C. Kelly Canelo; secretary, Alson R. Kilgore; assistant secretary, T. Henshaw Kelly; treasurer, Alson R. Kilgore; assistant treasurer, T. Henshaw Kelly.

They appointed Morton R. Gibbons, Sr., as medical director, and A. W. Widenham of San Francisco as general manager.

There is no need to describe Doctor Gibbons. Mr. Widenham was selected after careful investigation of the available applicants and some who were not applicants. He has worked with Doctor Wilbur, who testifies to his ability. For many years he was the secretary and manager of the Musical Association of San Francisco, which is the parent and operator of the San Francisco Symphony Orchestra. His business was to run subscribers, musicians and to do the main job of raising money every year. This work has given him a wide acquaintanceship and he has a most effective personality.

The trustees, according to the by-laws, appointed an executive committee consisting of T. Henshaw Kelly, Samuel Ayres, Jr., and Alson R. Kilgore. This committee is preparing, with the assistance of Mr. Peart, an abstract of the by-laws and authorized a series of questions and answers which were prepared by Doctors Goin and Ayres, and which deal with all of the aspects of the plan and its operation.

A committee is working on the proper districting of the state and another has the duty of establishing a fee schedule to be used in the unit system of compensating the professional members.

Doctors Kelly and Kilgore have been looking for offices for the Service and it would seem the sensible thing to establish it in the Mills Building, Bush and Montgomery streets, in San Francisco. This is a good building in the business district and the rents are quite reasonable compared to those in some of the other buildings.

The trustees propose to send to every licensed doctor of medicine an explanatory statement, the abstract of the by-laws, the rules and regulations and the questions and answers referred to above, and to include with this booklet an application for professional membership, and a letter urging each man to apply immediately. They propose to have a group in each county society or district ready to make contact with all of the men as soon as this material is mailed in order that each physician may be personally urged to join in the plan.

The trustees would like each councilor to suggest to them one or two men in his district who would be more or less representative of the physicians in that district, and with whom the committee might discuss the matter of the fee schedule and if there are societies with fee schedules in the district, to obtain copies of them for the committee's information.

The committee proposes shortly to call a meeting of men from the various districts and from various groups of practitioners to advise as to the fee schedule which will then soon be promulgated.

The office of the Service will be opened on February 15, as that is the day that Mr. Widenham, the general manager, is to take up his duties.

Shortly, the application blanks for professional membership will go out (as soon as they and the booklet can be printed and the envelopes addressed) and the organization of the professional membership will be in train.

It is important that the plan be functioning at the earliest moment and the trustees are doing everything they can to speed the day.

Sincerely,

EXECUTIVE COMMITTEE OF
CALIFORNIA PHYSICIANS' SERVICE
T. Henshaw Kelly, *Chairman*
Alson R. Kilgore
Samuel Ayres, Jr.

POSTGRADUATE CONFERENCES

Local Committees on Postgraduate Activities are at work on details concerning prospective courses in their respective districts. *Tentative* dates for courses soon to be announced include:

Santa Barbara District.

March 18 and 19, 1939. For information, address H. E. Henderson, M. D., 1421 State Street, Santa Barbara.

San Bernardino District.

April 4, 1939. For information, address F. E. Clough, M. D., 491 Fifth Street, San Bernardino.

San Mateo District.

Dates to be announced. J. Garwood Bridgman, Secretary.

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† For complete rosters of officers, see advertising pages 2, 4, and 6.

* For series of questions and answers concerning California Physicians' Service, see page 247.

EXECUTIVE COMMITTEE

Abstract of Mail Vote Taken on February 3, 1939

Chairman Kelly authorized a mail vote on expenditure of sum not to exceed $1,200 for insertion of a greeting announcement in the special editions of Bay Region newspapers, incident to the opening of Golden Gate International Exposition, as an expression of appreciation of past coöperation. A majority voted in favor of the expenditure.

MID-YEAR CONFERENCE OF CALIFORNIA MEDICAL ASSOCIATION OFFICERS AND COMMITTEES AND COUNTY SOCIETY SECRETARIES

The Third Annual Joint Conference of California Medical Association Councilors, California Medical Association Committeemen, and County Society Secretaries was held in the Franciscan Rooms, Sir Francis Drake Hotel, San Francisco, on Saturday, February 25, 1939. The sessions of the different groups began at 9:30 a. m., and adjournment took place shortly before six o'clock. In this issue of the Official Journal, it is possible to give only the outline of the proceedings, as follows:

PROGRAM

President W. W. Roblee, Riverside, Presiding

9:30 a. m.—Association Secretary's Announcements.

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Part I—Conferences

9:30-10:30 a. m.—County Secretaries' Round Table: Robert Peers, Colfax, presiding.

(Consideration of queries sent in by secretaries on their reply blanks, and of questions submitted at this Round Table Conference.)

9:30-10:30 a. m.—Reunion of Standing Committee Groups.

(Members of each committee are requested to confer with one another concerning their work, and chairman or other member to submit the committee's report at the afternoon session.)

9:30-10:00 a. m.—Council—Council Meeting, Chairman Karl Schaupp, presiding.

(Meeting will be held in usual place, Room 209, on the second floor. Councilors are requested to go to the room promptly to consider certain docket items concerning which action at this time is desirable.)

* * *

Part II—Symposium on Medical Service Activities

10:30-12 or 12:30 noon—(Ten to fifteen-minute talks, followed by Question Box period.)

Introductory Remarks.—President W. W. Roblee.

Health Service Backgrounds.—Ray Lyman Wilbur, Chairman, Board of Trustees, California Physicians' Service.

Work of the Special Committee on Medical Service Plans: In Retrospect.—President-Elect Charles A. Dukes.

California Physicians' Service: Program to Date.—T. Henshaw Kelly, Chairman, California Physicians' Service Executive Committee.

Plans of California Physicians' Service.—Morton R. Gibbons, Medical Director, California Physicians' Service.

Health Service Bills before California Legislature Now in Session.—Junius B. Harris, Chairman, California Medical Association Committee on Public Policy and Legislation.

Question Box Period.

(An informal discussion and exchange of views. Questions sent in on the reply blanks will be taken up. Other queries from the floor.)

* * *

Part III—Luncheon Recess

12:30-2:00 p. m.—(Delegates will be the guests of the California Medical Association. Luncheon will be served in the mezzanine balcony. Members of committees are requested to take places at the same tables.)

1:30 p.m.—Meeting of Administrative Members of the California Physicians' Service. (Place of meeting will be announced by Doctor Kilgore.)

Part IV—Special Reports

2:00 p m.—(Ten-Minute Progress Reports.)

Concerning Proposed Laws, Now Before the California Legislature.—Junius B. Harris, Chairman, Committee on Public Policy and Legislation.

California State Board of Public Health: Pending Legislation.—Howard Morrow, President of the Board of Public Health.

California State Board of Medical Examiners: Pending Legislation.—William R. Molony, Sr., President of the Board.

Del Monte Annual Session: May 1-4, 1939.—J. Homer Woolsey, Member, Committee on Scientific Work.

Department of Public Relations.—George G. Reinle, Chairman.

Cancer Commission.—Otto H. Pflueger, Secretary.

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Part V—Reports of Standing and Special Committees

(Five-Minute Progress Reports)

Standing Committees

Associated Societies and Technical Groups—John V. Barrow, Chairman.

Health and Public Instruction—Fred B. Clarke, Chairman.

History and Obituaries—Frank R. Makinson, Chairman.

Hospitals, Dispensaries, and Clinics—W. Earl Mitchell, Chairman.

Industrial Practice—Philip Stephens, Chairman.

Medical Defense—George G. Reinle, Chairman.

Medical Economics—John H. Graves, Chairman.

Medical Education and Medical Institutions—Loren R. Chandler, Chairman.

Membership and Organization—George D. Maner, Chairman.

Postgraduate Activities—John C. Ruddock, Chairman.

Publications—Ralph Eusden, Chairman.

Special Committees

Subcommittee on Pneumonia Control—Roy Thomas, Chairman.

Report of Special Committee on Cancer Exhibit at Golden Gate International Exposition—T. Henshaw Kelly, Chairman.

Report of Committee on County Hospitals—Louis Packard, Chairman.

Report of Committee on Farm Bureau Conferences—Henry S. Rogers, Chairman.

Report of Committee on Animal Experimentation—Philip K. Gilman, Chairman.

Report of Committee on Venereal Diseases—Howard Morrow, Chairman.

Report of Committee on Basic Science Law—George H. Kress, Chairman.

* * *

Part VI—Question-Box Hour: "The Good of the Order"

If time permits, and until adjournment hour is reached, the remainder of the session will be given over to questions on matters pertinent to "The Good of the Order." (May be state, county, local, or other nature.)

SENATE BILL NO. 1128*

An act to amend the title and Section 3 of, and to add Articles 11 to 16, inclusive, comprising Sections 151 to 358, inclusive, to the Unemployment Reserves Act, relating to a system of health insurance within the system of unemployment reserves.

The people of the State of California do enact as follows:

Section 1. The title of the Act cited in the title hereof is hereby amended to read as follows: . . .

Article 11. Health Insurance, Generally

Sec. 151. The provision of Articles 11 to 16 of this Act establish and provide for a plan of compulsory health insurance integrated with the system of unemployment insurance, together with plans of voluntary health insurance for which provision is made herein. . . .

Article 15. Organization of Medical Services

Sec. 300. All licensed physicians and surgeons may register under the Health Insurance Code for the purpose of entering into contracts with the State as independent contractors for rendering medical services to service beneficiaries and their dependents.

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* For editorial comment, see page 170.

Sec. 301. A service beneficiary may select any licensed physician and surgeon registered under this code for the purposes of securing general practitioner services for himself and his dependents. Every licensed physician and surgeon registered under this code is entitled to reject any service beneficiary and his dependents.

Sec. 302. Every registered physician and surgeon upon accepting a service beneficiary shall, until a change is made by him, or by the service beneficiary, be charged with the supervision of the health of the service beneficiary and his dependents and shall be obliged to render general practitioner services if and when such services are needed by the servic beneficiary and his dependents.

Sec. 303. Service beneficiaries failing to exercise their right to choose a licensed physician and surgeon registered under this code shall be assigned a registered physician and surgeon who has indicated himself as desirous of additional service beneficiaries for his list. At all times a service beneficiary shall be on the medical list of a licensed physician and surgeon registered under this code.

Sec. 304. A licensed physician and surgeon registered under this code shall receive remuneration to be determined by the number of service beneficiaries upon his medical list. The maximum number of service beneficiaries shall be determined by the governing authority after consultation with the advisory council.

Sec. 305. X-ray and laboratory services shall be performed by public laboratories and approved private laboratories which have contracted to render services at stipulated rates comparable to the costs of efficiently operated public laboratories.

Specialist and consultant services shall be rendered in public diagnostic centers which diagnostic centers shall be organized in various places throughout the State as adjuncts to selected public hospitals in the area. Specialist and consultant services may also be rendered in approved private diagnostic centers which are adjuncts to selected public hospitals or which are adjuncts to approved private hospitals rendering hospitalization services under this code. Approved private diagnostic centers and approved private hospitals shall be compensated in accordance with contracts prescribing the compensation at stipulated rates comparable to costs of efficiently operated public diagnostic centers and public hospitals.

Emergency specialist and consultant services shall be provided in accordance with the rules and regulations established by the medical director.

Sec. 306. Remuneration for all services not otherwise provided for in this code shall be fixed by the governing authority after consultation with the advisory council.

Sec. 307. Drugs and medicaments may be purchased from any pharmacy which has agreed to sell them at prices fixed by the governing authority.

Sec. 308. Service beneficiaries, notwithstanding the provisions of the foregoing sections, may choose any group unit of licensed physicians and surgeons who have associated themselves into a unit registered under this code for the purpose of providing medical services in accordance with the standards established pursuant to the code.

A registered group unit of licensed physicians and surgeons shall receive compensation under the supervision of the Medical Director upon the basis of a fixed amount per annum for the number of service beneficiaries upon its list, the amount of which to be dependent upon the scope of the medical services rendered to service beneficiaries by the group unit.

Article 16. Administration

Sec. 350. There is established in the Department of Employment a Bureau of Medical Service.

Sec. 351. The unemployment compensation benefit service of the Department of Employment shall collect, account for, prepare the records, and do the disbursing for the Bureau of Medical Service.

Sec. 352. The administration of the Bureau of Medical Service shall be vested in a director to be known as the Medical Director, who shall be appointed under the civil service by the governing authority of the department.

The Medical Director shall be assisted by an advisory council appointed by the Governor, which advisory council shall in all cases comprise three representatives of labor selected from panels presented by bona fide state-wide labor organizations in the State, and two representatives of employers selected from panels presented by bona fide employer organizations of the State.

When serving as an advisory council to the Bureau of Medical Service, there shall be added to the council a representative of the medical schools selected from a panel presented by the bona fide medical schools in the State, and a licensed physician and surgeon selected from a panel presented by the licensed physicians and surgeons registered under the code.

Sec. 353. The Medical Director appointed under civil service shall be a licensed physician and surgeon who has had at least ten years in the active practice of medicine.

Sec. 354. The State shall be divided into medical service districts, each of which shall be in charge of a district medical supervisor selected in accordance with the State Civil Service Act. The district medical supervisors shall be licensed physicians and surgeons who have had at least five years in the active practice of medicine.

Sec. 355. In each district there shall be established a panel committee selected by the licensed physicians and surgeons registered under the code, which committee shall serve in an advisory capacity to the district medical supervisors. The panel committees in each district shall, by post-card ballot, select the panel from which the Governor shall select a representative to represent the licensed physicians and surgeons registered under this code upon the advisory council.

In addition, in each medical service district, panel committees shall be established, consisting of representatives of professional groups engaged in rendering medical service benefits under the provisions of the Health Insurance Code, and they shall likewise be entitled to select the panel by post-card ballot election, from which the Governor may appoint a representative upon the advisory council.

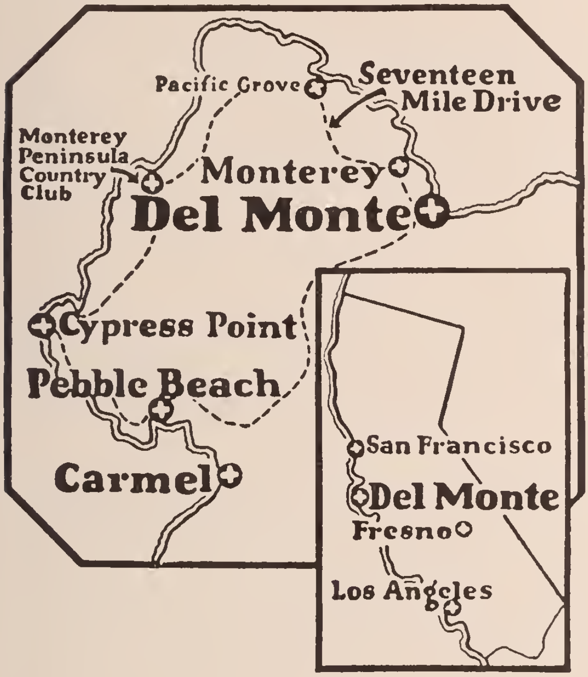
Sec. 356. The Medical Director may establish a Bureau of Accounting and Efficiency for the purpose of making cost analyses and determining the most efficient method of organizing and administering the system of medical services established under this code.

Sec. 357. The governing authority after consultation with the Medical Director and the advisory council shall prepare rules and regulations governing the administration of disability unemployment benefits and medical benefits.

Sec. 358. The Medical Director after consultation with the advisory council shall prepare rules and regulations governing disciplinary action to be taken in regard to all individuals and their dependents insured under the provisions of this code, licensed physicians and surgeons registered under this code, and any other person or group of persons rendering services under this code who are guilty of violating their obligations in respect to disability, unemployment benefits and medical benefits.

Rules and regulations governing disciplinary action against any individual against whom disciplinary action may be taken under this section shall in all cases make provision for both a hearing and consultation with the proper panel committee before any recommendation may be made by a district medical officer and shall permit actual deprivation of privileges only by the Medical Director and only after consultation with the advisory council and an appellate body, one member of which shall be a member of the professional or technical group to which the person accused belongs, has conducted a review relative to the district recommendation.

HOTEL AND AUTOMOBILE COURT RATES FOR DEL MONTE ANNUAL SESSION



Hotel rates of the hotels at Del Monte and on the Monterey Peninsula were given in the February issue, on pages 137 and 138.

Additional information concerning location of automobile courts appears below.

With the large attendance in prospect for the May 1–4, 1939, annual session meetings at Del Monte, hotel reservations in advance are advised.

Seventeen-Mile Drive Auto Court

The Seventeen-Mile Drive Cottage Court is located at the entrance to the Seventeen-Mile Drive, and rates are $1 and up per day. Fred W. Workman, Manager, Corner Sinex Street and Seventeen-Mile Drive, Pacific Grove, California. P. O. Box, 529. Telephone, Monterey, 6552.

* * *

Mikel's Cottages

Mikel's Cottages are located in Pacific Grove, and the rates run $2 single, $2.50 double, and up. Mikel's Cottages are de luxe, quiet and homelike, located in the pines. N. Mikel, Owner, 1073 Lighthouse Avenue, Pacific Grove, California. Telephone, 8860.

* * *

Pine Oak Auto Court

The Pine Oak Auto Court is located one-half mile east of Del Monte, and has cottages from $1 up; their accommodations all have nice beds and practically all are equipped with showers. D. C. Cooper, Manager, 2149 Fremont Street, East Monterey, California. Telephone, Monterey 5288.

C. M. A. DEPARTMENT OF PUBLIC RELATIONS[†][*]

CALIFORNIA LEGISLATURE—FIFTY-THIRD SESSION

List of proposed statutes having a relationship to medical practice and public health activities, submitted in the month of January, 1939, is given below. February, by law, is a constitutional recess, and the Legislature is not in session. The final session opens on March 6.

Members of the California Medical Association may well glance over the list which follows.

The letters "A. B." mean Assembly Bill. The names of the Assemblyman or Assemblymen who introduced the bill are also given. The letters "S. B." mean Senate Bill.

Members who desire copies of certain bills may write to the California State Printer, Sacramento; or to Joseph A. Beck, Secretary of the California Senate, Sacramento; or to J. C. Greenburg, Clerk, California Assembly, Sacramento, giving always the number of the bill desired and stating whether it is an Assembly or Senate bill.

Board of Health
(Nine Bills)

A. B. 1215, by Rosenthal, by request (referred to Committee on Public Health and Quarantine). Places Director of Public Health in charge of Department and gives him all of duties of State Board of Public Health.

A. B. 1216, by Rosenthal, by request (referred to Committee on Public Health and Quarantine). Establishes State Board of Public Health to act solely in advisory capacity. Fixes salary of Director at $10,000 per year.

A. B. 2107, by Dills (referred to Committee on Governmental Efficiency and Economy). Identical with A. B. 1215.

A. B. 2108, by Dills (referred to Committee on Governmental Efficiency and Economy). Identical with A. B. 1216.

S. B. 1054, by Kenny and Shelley (referred to Committee on Public Health and Quarantine). Identical with A. B. 1215.

S. B. 1055, by Kenny and Shelley (referred to Committee on Public Health and Quarantine). Identical with A. B. 1216.

S. B. 1217, by Powers (referred to Committee on Public Health and Quarantine). Requires health officers to report epilepsy.

S. B. Bills 1043 and 1044, by Nielsen (referred to Committee on Public Health and Quarantine). Requires health officers to report epilepsy.

Chiropody
(Four Bills)

A. B. 531, by Gannon (referred to Committee on Medical and Dental Laws). Requires one year of prechiropodical work of college grade.

A. B. 532 by Gannon (referred to Committee on Medical and Dental Laws). Relates to advertising.

S. B. 1083, by Jesperson (referred to Committee on Public Health and Quarantine). Identical with A. B. 531.

S. B. 1084, by Jesperson (referred to Committee on Public Health and Quarantine). Identical with A. B. 532.

Chiropractors
(One Bill)

A. B. 2176, by Reaves (referred to Committee on State Colleges). Relates to courses of instruction at Fresno State College, providing for instruction in advanced chiropractic and in school nursing, and making an appropriation.

Codes
(One Bill)

S. B. 657, by Mixter and Foley (referred to Committee on Public Health and Quarantine). Establishes a Health and Safety Code.

Compensation Act
(Seventeen Bills)

A. B. 419, by Rosenthal (referred to Committee on Labor and Capital). Adds persons on unemployment work relief program to definition of "employee."

[†] The complete roster of the Committee on Public Relations is printed on page 2 of the front advertising section of each issue. Dr. George G. Reinle of Oakland is the chairman and Dr. George H. Kress is the secretary. Component county societies and California Medical Association members are invited to present their problems to the committee. All communications should be sent to the director of the department, Dr. George H. Kress, Room 2004, Four Fifty Sutter Street, San Francisco.

[*] For additional Comment in this issue, see page 247 (first column).

A. B. 499, by Tenney (referred to Committee on Insurance). Increases benefits.

A. B. 500, by Tenney and Dills (referred to Committee on Insurance). Similar to A. B. 419.

A. B. 640, by Sawallisch (referred to Committee on Insurance). Adds pneumonia and heart trouble to "injuries" of police, fire and forestry department members for compensation awards.

A. B. 724, by Donnelly (referred to Committee on Labor and Capital). Excludes sheep shearers from definition of "employee."

A. B. 958, by Tenney (referred to Committee on Insurance). Amends Compensation Act, relating to inspection of medical records.

A. B. 1519, by Atkinson (referred to Committee on Insurance). Relates to payments.

A. B. 1520, by Atkinson (referred to Committee on Insurance). Inspection of x-ray films, reports, hospital and doctors' records, clinical, laboratory and other tests.

A. B. 1522, by Atkinson (referred to Committee on Insurance). Relates to disability.

A. B. 1526, by Atkinson (referred to Committee on Insurance). Brings farm employees under definition of "employee."

A. B. 1531, by Atkinson (referred to Committee on Insurance). Brings domestics and newsboys under definition of "employee."

A. B. 1696, by Gilbert (referred to Committee on Unemployment). Benefits for injured relief workers.

A. B. 2177, by Reaves (referred to Committee on Insurance). Employee entitled to select, without restraint, anyone licensed to treat in any manner the type of injury which he has sustained.

A. B. 2253, by Pelletier (referred to Committee on Insurance). Brings newspaper vendors under definition of "employee."

S. B. 250, by Foley (referred to Committee on Labor and Capital). Identical with A. B. 958.

S. B. 349, by Keating (referred to Committee on Labor and Capital). Relates to medical evidence in proceedings before Industrial Accident Commission.

S. B. 598, by Westover (referred to Committee on Labor and Capital). Relates to claims for Workmen's Compensation by State agencies.

Dentistry
(Ten Bills)

A. B. 1493 and A. B. 1494, by Meehan (referred to Committee on Medical and Dental Laws). Relates to the definition of dentistry.

A. B. 1707 and A. B. 1708, by Johnson (referred to Committee on Education). Relates to absence of pupils from school for dental services.

A. B. 1766, by Cronin (referred to Committee on Medical and Dental Laws). Requires applicants for licenses to practice dentistry to be citizens of U. S. A.

A. B. 1826 and A. B. 1827, by Hugh M. Burns and Cronin (referred to Committee on Medical and Dental Laws). Relates to registration of dentists and dental hygienists.

A. B. 2189, by Cronin (referred to Committee on Medical and Dental Laws). Relates to qualifications for practice of dentistry.

S. B. 989 and S. B. 990, by Carter (referred to Committee on Public Health and Quarantine). Relates to Dental Corporation of California, its organization, membership, government and powers, the practice of dentistry and dental hygiene.

Dispensing Opticians
(Four Bills)

A. B. 516, by Cronin (referred to Committee on Medical and Dental Laws). Establishes State Board of Dispensing Opticians.

A. B. 517, by Cronin (referred to Commmittee on Medical and Dental Laws). Relates to the business of dispensing optician.

A. B. 1666, by Sawallisch (referred to Committee on Medical and Dental Laws). Relates to persons engaged in and training for the vocation of optical dispensing.

S. B. 1226, by Jerperson (referred to Committee on Governmental Efficiency). Identical with A. B. 1666.

Health and Hospital Insurance
(Fifteen Bills)

A. B. 610, by Kepple (referred to Committee on Judiciary Codes). Relates to hospitals eligible to enter into contracts under nonprofit hospital service plans.

A. B. 1573, by Hugh M. Burns (referred to Committee on County Government). Relates to care and treatment at county expense of persons requiring the same.

A. B. 1711, by Johnson (referred to Committee on Insurance). Relates to insurance corporations issuing hospitalization, medical and dental benefits.

A. B. 1712, by Johnson (referred to Committee on Insurance). Nonprofit hospital service plans.

A. B. 2101, by Desmond (referred to Committee on Insurance). Relates to powers of boards of supervisors to adopt a system of life, health and accident insurance for the benefit of county employees and to pay the whole or any part of the premiums thereof.

A. B. 2103, by Desmond (referred to Committee on Insurance). Same provisions of A. B. 2101 to apply to governing bodies of school districts, municipal corporations, political subdivisions, public corporations and other public agencies of the State of California.

A. B. 2172, by Rosenthal, Atkinson, Dills, Gilmore, Cassidy, Kilpatrick, King, Del Mutolo, Collins, Hawkins, Gilbert, Gallagher, O'Day, Richie and Voigt (referred to Committee on Unemployment). Provides a system of health insurance within the system of unemployment reserves.

A. B. 2349, by Sheridan (referred to Committee on Insurance). Relates to forms of disability insurance policies which may be issued.

A. B. 2494, by Garland (referred to Committee on Insurance). Provides for regulation of insurance against the need for medical and hospital service.

A. B. 2501, by Garland (referred to Committee on Insurance). Companion measure to A. B. 2494.

S. B. 548, by Hollister (referred to Committee on Insurance). Relates to nonprofit hospital and health service plans.

S. B. 551, by Hollister (referred to Committee on Labor and Capital). Amends Labor Code to provide statewide system of health insurance.

S. B. 1128, by Kenny and Shelley (referred to Committee for Social Security, Pensions and Relief). Identical with A. B. 2172.

S. B. 1171, by Nielsen (referred to Committee on Governmental Efficiency). Identical with A. B. 2103.

S. B. 1172, by Nielsen (referred to Committee on County Government). Identical with A. B. 2101.

Hospitals
(Three Bills)

A. B. 1727, by Pelletier (referred to Committee on Judiciary General). Relates to hospital records.

A. B. 2385, by Meehan (referred to Committee on Hospitals and Asylums). Provides for inspection and regulation of private hospitals, sanitariums, homes for orphan children, nursing homes, homes for aged persons and similar institutions.

A. B. 2499, by Garland (referred to Committee on Social Service and Welfare). County hospital bill.

Health Officers
(Two Bills)

A. B. 444, by Evans (referred to Committee on Public Health and Quarantine). Relates to city and county health officers).

A. B. 2367, by Hugh M. Burns (referred to Committee on County Government). Relates to powers and duties of county health officers.

Insane
(Eighteen Bills)

A. B. 719, by Lore, Doyle, Lyon and Tenney (referred to Committee on Social Service and Welfare). To provide an institution for the confinement, care, training and rehabilitation of defective or psychopathic delinquents.

A. B. 2323, by Daley, Cassidy, Massion, Voigt, O'Day, Andreas and Richie (referred to Committee on Hospitals and Asylums). Designates Department of Institutions and the director thereof as the Department of Mental Hygiene and Director of Mental Hygiene and providing for his qualifications.

A. B. 2324, by Daley, Cassidy, Massion, O'Day, Voigt, Andreas and Richie (referred to Committee on Hospitals and Asylums). Amends code relating to epileptic and feeble-minded persons.

A. B. 2325, by Daley, Cassidy, Massion, O'Day, Voigt, Andreas and Richie (referred to Committee on Hospitals and Asylums). Relates to persons employed in State hospitals.

A. B. 2326, by Daley, Cassidy, Massion, O'Day, Richie, Andreas and Voigt (referred to Committee on Hospitals and Asylums). Relates to notice to creditors.

A. B. 2327, by Cassidy, Massion, O'Day, Richie, Andreas, Voigt and Daley (referred to Committee on Hospitals and Asylums). Relates to insane and incompetent persons.

A. B. 2328, by Cassidy, Massion, Richie, Andreas, O'Day, Voigt and Daley (referred to Committee on Hospitals and Asylums). Relates to insane defendants in criminal cases.

A. B. 2331, by Cassidy, Massion, Richie, O'Day, Andreas, Voigt and Daley (referred to Committee on Hospitals and Asylums). Relates to private institutions for the care of insane or incompetent persons.

A. B. 2334, by Cassidy, Massion, O'Day, Richie, Andreas, Voigt and Daley (referred to Committee on Hospitals and Asylums). Relates to support of persons confined in State hospitals.

A. B. 2335, by Cassidy, Massion, O'Day, Voigt, Andreas, Richie and Daley (referred to Committee on Hospitals and Asylums). Relates to transfers of inmates between State homes for feeble-minded and to support of inmates so transferred.

A. B. 2336, by Cassidy, Massion, O'Day, Richie, Andreas, Voigt and Daley (referred to Committee on Hospitals and Asylums). Relates to the acute psychiatric hospital.

A. B. 2337, by Cassidy, Massion, Richie, O'Day, Andreas, Voigt and Daley (referred to Committee on Hospitals and Asylums). Relates to insane persons.

A. B. 2603, by Cronin (referred to Committee on Governmental Efficiency and Economy). Appointment of Secretary of Department of Institutions as guardian or administrator.

S. B. 382, by Kenny (referred to Committee on Social Security, Pensions and Relief). Relates to maintenance of persons mentally disordered and bordering on insanity but not dangerously insane.

S. B. 524, by Kenny (referred to Committee on Hospitals and Asylums). Companion measure to A. B. 719.

S. B. 526, by Kenny (referred to Committee on Hospitals and Asylums). Relates to private institutions for mentally ill or deranged persons.

S. B. 769 and S. B. 770, by Deuel (referred to Committee on Judiciary). Relates to the plea of insanity and proof thereunder.

Medical Practice Act

(Seventeen Bills)

A. B. 437, by Doyle (referred to Committee on Medical and Dental Laws). Relates to signs and advertisements in connection with the practice of medicine.

A. B. 438, by Doyle (referred to Committee on Medical and Dental Laws). Relates to disciplinary proceedings within the chapter on medicine.

A. B. 449, by Gannon (referred to Committee on Medical and Dental Laws). Relates to citizenship of applicants to practice medicine.

A. B. 468, by Cronin (referred to Committee on Medical and Dental Laws). Relates to the practice of medicine and surgery by graduate students and internes.

A. B. 469, by Cronin (referred to Committee on Medical and Dental Laws). Relates to false and untrue statements by licensed persons.

A. B. 470, by Cronin (referred to Committee on Medical and Dental Laws). Relates to peace officers.

A. B. 477, by Massion (referred to Committee on Medical and Dental Laws). Relates to unprofessional conduct in the practice of medicine and use of title "Doctor" or "Dr."

A. B. 478, by Johnson (referred to Committee on Medical and Dental Laws). Relates to the scope of practice of medicine and surgery permitted under a drugless practitioner's certificate.

A. B. 479, by Johnson (referred to Committee on Governmental Efficiency and Economy). Relates to bonds for costs in actions upon disciplinary orders.

A. B. 484, by Kepple (referred to Committee on Medical and Dental Laws). Relates to remedies for the enforcement of the chapter on medicine. Injunction may be granted.

A. B. 496, by Massion (referred to Committee on Medical and Dental Laws). Relates to the use of the term "drugless practitioner."

A. B. 511, by Johnson (referred to Committee on Education). Relates to colleges and seminaries of learning.

A. B. 1505, by Gannon (referred to Committee on Medical on Dental Laws). Relates to unprofessional conduct.

A. B. 2745, by Johnson, by request (referred to Committee on Medical and Dental Laws). Relates to a review of disciplinary action of the Board of Medical Examiners.

S. B. 234, by Quinn (referred to Committee on Public Health and Quarantine). Relates to graduates of Canadian medical schools.

S. B. 913, by Hollister (referred to Committee on Judiciary). Relates to sale of degrees, certificates and transcripts connected with the treatment of the sick or afflicted.

S. B. 1182, by Carter (referred to Committee on Governmental Efficiency). Adds to Business and Professions Code. Relates to judicial review.

Narcotics

(Seven Bills)

A. B. 2212, 2213, 2319, 2322, 2463, 2482, 2606.

Naturopathy

(Two Bills)

A. B. 1203, by Voigt, Gilbert, Pelletier, Reaves and Richie (referred to Committee on Medical and Dental Laws). Regulates persons engaged in and training for the practice of naturopathy and the schools instructing persons to engage therein.

A. B. 2315, by Gilmore (referred to Committee on Medical and Dental Laws). Relates to the raising of educational qualifications of the drugless practitioner.

Nursing

(Six Bills)

A. B. 563, by Fulcher (referred to Committee on Medical and Dental Laws). Practical Nursing Act.

A. B. 564, by Fulcher (referred to Committee on Governmental Efficiency and Economy. Relates to the Board of Practical Nurse Examiners.

A. B. 619, by Cronin, Hugh M. Burns, Poulson, Meehan, Field, Call, Robertson, Sawallisch, Allen, Redwine, Daley and Eleanor Miller (referred to Committee on Medical and Dental Laws). Establishes Board of Nurse Examiners.

A. B. 620, by same authors as A. B. 619 (referred to Committee on Medical and Dental Laws). Nursing Practice Act.

S. B. 960, by Kenny and Biggar (referred to Committee on Governmental Efficiency). Identical with A. B. 619.

S. B. 961, by Kenny and Biggar (referred to Committee on Public Health and Quarantine). Identical with A. B. 620.

Optometry

(Five Bills)

A. B. 1718, by George P. Miller (referred to Committee on Medical and Dental Laws). Relates to the advertising of glasses and of optometry.

A. B. 1720, by Redwine (referred to Committee on Medical and Dental Laws). Relates to registered optometrists.

A. B. 2627, by Lyon (referred to Committee on Governmental Efficiency and Economy). Relates to admission to the practice of optometry.

A. B. 2628, by Lyon (referred to Committee on Governmental Efficiency and Economy). Relates to disciplinary actions under the chapter on optometry.

A. B. 2633, by George P. Miller (referred to Committee on Governmental Efficiency and Economy). Relates to offenses against the chapter on optometry.

Osteopathy

(One Bill)

A. B. 2346, by Daley (referred to Committee on Education). Relates to health and development certificates.

Pharmacy and Drugs

(Twenty-three Bills)

A. B. 450, 472, 689, 1018, 1019, 1067, 1131, 1147, 1177, 1574, 1695, 1830, 2080, 2441, 2722.

S. B. 517, 792, 817, 818, 819, 820, 1208, 1215.

Radio Advertising

(One Bill)

A. B. 666, by Gilbert (referred to Committee on Crime Problems). Relates to false advertising by radio and providing penalties for violation thereof.

Physically Defectives

(Seven Bills)

A. B. 1068, 1069, 1070, 1071, 2112, 2338. S. B. 658.

Public Medical Care

(One Bill)

A. B. 1874, by Del Mutolo (referred to Committee on Medical and Dental Laws). An act to promote the public health by providing for public medical care, including medical, dental, nursing, hospital, pharmaceutical and therapeutic appliance care for needy persons; providing for the apportionment of the cost of such medical care between the State and the counties and providing for the administration and enforcement thereof.

Sales Tax

(Six Bills)

A. B. 10 and A. B. 11, by Rosenthal (referred to Committee on Ways and Means). Exempts medicines.

A. B. 33 and A. B. 34, by Houser (referred to Committee on Revenue and Taxation). Exempts medicines.

A. B. 235 and A. B. 236, by Redwine (referred to Committee on Revenue and Taxation). Exempts orthopedic supplies.

Tuberculosis

(Six Bills)

A. B. 1117 and 1118, by Daley (referred to Committee on Social Service and Welfare). Relates to grants in aid for persons afflicted with tuberculosis.

A. B. 1184, by Lore (referred to Committee on Ways and Means). Appropriation for Bureau of Tuberculosis, Department of Health, for purpose of conducting a survey as to the prevalence of tuberculosis among persons on relief.

A. B. 1307, by Gilbert and Andreas (referred to Committee on Social Service and Welfare). Relative to aid for convalescing tuberculous persons.

A. B. 1964, by Garland (referred to Committee on Education). Relates to physical examinations of teachers for active tuberculosis.

S. B. 696, by Mixter (referred to Committee on Education). Companion measure to A. B. 1964.

(Continued on Page 217)

CALIFORNIA LEGISLATURE, 1939—FIFTY-THIRD SESSION

Query: Have you sent the number of your Assembly District to the central office? In the roster of Assemblymen, given below, do you know the name of the Assemblyman in whose district you live?

MEMBERS OF THE ASSEMBLY AND ADDRESSES—CALIFORNIA LEGISLATURE—FIFTY-THIRD SESSION, 1939

Name	*Occupation*	*Party*	*District*	*Home Address*	*Sacramento Address*
Allen, Don A.	Engineer	D	63	1226 W. 30th Street, Los Angeles	Hotel Sacramento
Andreas, Godfrey A.	Orange Grower	D	72	515 W. 17th St., Upland	
Atkinson, Maurice E.	Journalist	D	70	906 Obispo Ave., Long Beach	2405 D Street
Bashore, Lee T.	Rancher	R	49	250 Live Oak, Glendora	Hotel Governor
Bennett, F. Ray	Attorney	D	51	5041 Gafford Street, Los Angeles	910 O Street
Burns, Hugh M.	Funeral Director	D	36	2055 San Joaquin Street, Fresno	Hotel Senator
Burns, Michael J.	Master Mechanic	R	1	1644 Summer Street, Eureka	3135 42nd Street
Burson, Roscoe W.	Farmer	R	40	Fillmore	Hotel Sacramento
Call, Harrison William	Attorney	R	29	Eaton Drive, Redwood City	Hotel Sacramento
Carlson, Arthur W.	Attorney	R	16	Piedmont	Hotel Senator
Cassidy, James M.	Mfr.'s Representative	D	13	1520 89th Avenue, Oakland	Hotel Lenhart
Clarke, George A.	Farmer	R	33	Rt. 1, Box 54, Le Grand	Hotel Berry
Collins, George D., Jr.	Attorney	D	22	1456 Union Street, San Francisco	Elks Club
Corwin, Gordon W.	Citrus Grower	R	73	749 Chestnut Avenue, Redlands	Hotel Sacramento
Cronin, Melvyn I.	Attorney	R	25	1424 5th Avenue, San Francisco	Hotel Senator
Crowley, Ernest C.	Attorney	D-R	5	Suisun	
Daley, Jeanette E.	Contractor	D	78	4430 Boundary Street, San Diego	Lewis Apartments
Del Mutolo, M. G.	Attorney	D	31	1731 Glen Una Way, San Jose	Hotel Berry
Desmond, Earl D.	Attorney-Farmer	D	9	2022 22nd Street, Sacramento	2022 22nd Street
Dills, Ralph C.	Teacher	D	69	1505 N. Spring Street, Compton	514-A 13th Street
Dilworth, Nelson S.	Farmer	R	76	119 N. Buena Vista Street, Hemet	
Donnelly, Hugh P.	Insurance	D	32	114 Lyons Avenue, Turlock	Hotel Sacramento
Doyle, Thomas J.	Business Manager-Retired Railway Conductor	D	45	4333 Griffin Avenue, Los Angeles	901 26th Street
Evans, John W.	Accountant	D	65	717½ W. 46th Street, Los Angeles	Hotel Sacramento
Field, C. Don	Trucking Contractor	R	43	1552 Rideway Drive, Glendale	1116 O Street
Fulcher, Clinton J.	Garage	D	2	Lookout	Hotel Sacramento
Gallagher, Dan	Drayman	D	23	1670 Folsom Street, San Francisco	Elks Club
Gannon, Chester F.	Attorney	D	8	3543 H St., Sacramento	613 Capital National Bank Bldg.
Garland, Gordon H.	Citrus Grower-Farmer	D	38	Woodlake	3020 10th Avenue
Gilbert, Wilbur F.	Mechanical Engineer	D	54	3537 The Paseo, Los Angeles	Hotel Sacramento
Gilmore, Joseph P.	Secretary	D	21	442 Excelsior Avenue, San Francisco	Hotel Berry
Green, Robert Miller	Attorney	R	28	214 19th Avenue, San Francisco	Hotel Senator
Hawkins, Augustus F.	Business	D	62	719 E. 43rd Place, Los Angeles	2790 43rd Street
Heisinger, S. L.	Farmer-Poultryman	D	37	Rt. 4, Box 90E, Fresno	Hotel Lenhart
Houser, Frederick F.	Attorney	R	53	19 W. Pine Street, Alhambra	Hotel Senator
Johnson, Gardiner	Attorney	R	19	765 San Luis Road, Berkeley	Elks Club
Kellems, Jesse Randolph	Minister	R	60	454 Cuesta Way, Bel-Air, Los Angeles	Hotel Sacramento
Kepple, Gerald C.	Attorney	R	50	1952 Valley View, Whittier	1124 45th Street
Kilpatrick, Vernon	Publisher	D	55	1116 S. Flower Street, Los Angeles	1217 15th Street
King, Cecil R.	Merchant	D	67	1152 W. 88th Street, Los Angeles	Hotel Sacramento
Knight, T. Fenton	Rancher	R	48	Rt. 1, Box 390, La Canada	Park Mansions Apartments
Kuebel, Thomas H.	Attorney	R	75	Bank of America Bldg., Anaheim	Sutter Club
Leonard, Jacob M.	Commercial Secretary	R	34	Hollister	Hotel Sacramento
Lore, Elmer E.	Printer	D	42	6304 Rodford, North Hollywood	1522 O Street
Lyon, Charles W.	Attorney	R	59	1052 S. Redondo Blvd., Los Angeles	Hotel Sacramento
Maloney, Thomas A.	Insurance	R	20	350 Missouri Street, San Francisco	Hotel Senator
Massion, Jack	Druggist	D	66	846 E. 77th Street, Los Angeles	Hotel Sacramento
Meehan, Henry P.	Insurance Broker	D	17	4143 Grove Street, Oakland	Hotel Land
Miller, Eleanor	Teacher	R	47	251 S. Oakland Avenue, Pasadena	Hotel Regis
Miller, George P.	Civil Engineer	D	14	1424 Benton Street, Alameda	
Millington, Seth	Lawyer	D	4	Gridley	Hotel Sacramento
O'Day, Edward F.	Attorney	D	24	1353 Church Street, San Francisco	Hotel Berry
O'Donnell, John H.	Attorney	D	3	608 Cleveland St., Woodland	608 Cleveland St., Woodland
Peek, Paul	Attorney	D	71	2363 Pine Avenue, Long Beach	
Pelletier, John B.	Research	D	44	248 S. Olive Street, Los Angeles	Hotel Lenhart
Phillips, James H.	Attorney	R	18	27 Contra Costa Place, Oakland	3721 27th Street
Poulson, Norris	Certified Public Acc'tant	R	56	3729 Tracy Street, Los Angeles	Hotel Berry
Reaves, Fred	Engineer	D	68	964 10th Street, San Pedro	Hotel Lenhart
Redwine, Kent H.	Attorney	R	57	1618 N. Las Palmas Avenue, Los Angeles	Hotel Senator
Richie, Paul A.		D	79	4264 Menlo Avenue, San Diego	Hotel Berry
Robertson, Alfred W.	Attorney	D	39	15 W. Carrillo, Santa Barbara	1110 11th Street
Rosenthal, Ben	Attorney	D	52	1924 E. 4th Street, Los Angeles	2226 28th Street
Salsman, Byrl R.	Attorney	R	30	1861 Fulton Street, Palo Alto	Hotel Sacramento
Sawallisch, Harold F.	Attorney	D	10	437 15th Street, Richmond	Hotel Sacramento
Scudder, Hubert B.	Insurance-Real Estate	R	7	506 S. Main Street, Sebastopol	Hotel Sacramento
Sheridan, Bernard A.	Attorney	R	15	2314 Mitchell Street, Oakland	
Stream, Charles W.	Real Estate-Insurance	R	80	P. O. Box 21, Palm City	Hotel Sacramento
Tenney, Jack B.	Attorney	D	46	724 E. Fairview Blvd., Inglewood	Ingram Apts., 14th & O
Thorp, James E.	Farmer	R	12	Lockeford	1404 P Street
Thurman, Allen G.	Newspaperman	R	6	Colfax	Hotel Land
Turner, Rodney L.	Farmer	D	41	1117 Jefferson Street, Delano	Elks Club
Voigt, Ernest O.	Real Estate	D	61	3651 Cardiff Avenue, Los Angeles	
Walker, Clarence R.	Farmer	R	77	Westmorland	Hotel Sacramento
Waters, Frank J., Jr.	Lawyer	R	58	1163 4th Avenue, Los Angeles	Hotel Berry
Watson, Clyde A.	Orange Grower	D	74	273 N. Harwood Street, Orange	Hotel Berry
Weber, Charles M.	Civil Engineer-Farmer	R	11	300 First National Bldg., Stockton	Elks Club
Weybret, Fred	Retired	R	35	Star Route, Soledad	Hotel Sacramento
Williamson, Ray	Attorney	R	26	41 Roselyn Terrace, San Francisco	Hotel Senator
Wollenberg, Albert C.	Attorney	R	27	2748 Steiner Street, San Francisco	Hotel Senator
Yorty, Samuel William	Manufacturing	D	64	463 S. Lake Street, Los Angeles	

MEMBERS OF THE CALIFORNIA SENATE: FIFTY-THIRD SESSION, 1939—NAMES, ADDRESSES, OCCUPATIONS

Name	*Occupation*	*Party*	*District*	*Counties*	*Home Address*	*Sacramento Address*
Biggar, George M.	Farmer	R-D	4	Mendocino, Lake	Covelo	Hotel Clunie
Breed, Arthur H., Jr.	Real Estate	R-D	16	Alameda	315 15th Street, Oakland	Senate Chamber
Brown, Charles	Merchant	D-R	28	Inyo, Mono	Shoshone	Senate Chamber
Carter, Jesse W.	Attorney	D	5	Shasta, Trinity	Redding	Senate Chamber
Collier, Randolph	Title business	R	2	Siskiyou, Del Norte	Yreka	Senate Chamber
Crittenden, Bradford S.	Attorney	R-D	20	San Joaquin	145 E. Harding Way, Stockton	Senate Chamber
Cunningham, R. R.	Real Estate, Ins.	D	27	Kings	Hanford	Elks Club
DeLap, T. H.	Attorney	R-D	17	Contra Costa	Amer. Trust Bldg., Richmond	Senate Chamber
Deuel, Charles H.	Publisher	D-R	6	Butte	396 East 4th Street, Chico	Senate Chamber
Fletcher, Ed.	Land, Water Devel.	R-D	40	San Diego	1020 9th Street, San Diego	Senate Chamber
Foley, John D.	Attorney	D	18	Santa Clara	2000 The Alameda, San Jose	Senate Chamber
Garrison, J. C.	Farmer	D	22	Stanislaus	Rt. 1, Box 1826, Modesto	Senate Chamber
Gordon, Frank L.	Farmer	R-D	11	Napa, Yolo	Suisun	Senate Chamber
Hays, Ray W.	Attorney	R	30	Fresno	610 Brix Bldg., Fresno	Senate Chamber
Hollister, J. James	Rancher	D	31	Santa Barbara	Gaviota	Senate Chamber
Holohan, James B.	Orchardist	D	23	Santa Cruz	Watsonville	Senate Chamber
Jespersen, Chris N.	Farmer	R	29	San Luis Obispo	Atascadero	Hotel Sacramento
Keating, Thomas F.	Attorney	D	13	Marin	Freitas Bldg., San Rafael	Senate Chamber
Kenney, Robert W.	Attorney	D	38	Los Angeles	711 Title Guar. Bldg., L. A.	Senate Chamber
Law, Edward H.	Attorney	D	39	Imperial	634 Hamilton, El Centro	Senate Chamber
Mayo, Jesse M.	Publisher	R-D	26	Tuolumne, Mariposa, Calaveras	Angels Camp	Senate Chamber
McBride, James J.	Insurance	D	33	Ventura	471 E. Main St., Ventura	Hotel Sacramento
McCormack, Thomas	Rancher	R-D	15	Solano	Rio Vista	Senate Chamber
Metzger, D. Jack	Rancher	R-D	8	Tehama, Glenn, Colusa	Red Bluff	Senate Chamber
Mixter, Frank W.	Druggist	R-D	32	Tulare	Exeter	Hotel Sacramento
Myhand, Peter P.	Rancher	D	24	Merced, Madera	501 19th Street, Merced	Hotel Senator
Nielsen, Roy J.	Insurance	R-D	19	Sacramento	Bank of Amer. Bldg., Sacramento	Bank of Amer. Bldg.
Parkman, Harry L.	Wholesaler, Jobber	R	21	San Mateo	934 Rosewood Dr., San Mateo	Hotel Sacramento
Phillips, John		R	37	Riverside	65 N. 4th Street, Banning	Senate Chamber
Pierovich, A. L.	Attorney	D-R	9	El Dorado, Amador, Alpine	8 Court Street, Jackson	Hotel Senator
Powers, Harold J.	Rancher	R-D	1	Modoc, Lassen, Plumas	Eagleville	Hotel Senator
Quinn, Irwin T.	Attorney	D	3	Humboldt	2205 H Street, Eureka	Senate Chamber
Rich, W. P.	Attorney	R-D	10	Yuba, Sutter	Marysville	Senate Chamber
Seawell, Jerrold L.	Insurance	R-D	7	Placer, Sierra, Nevada	303 Mariposa Ave., Roseville	Senate Chamber
Shelley, John F.	Labor Executive	D-P	14	San Francisco	536 Octavia Street, S. F.	Senate Chamber
Slater, Herbert W.	Publisher	D-R	12	Sonoma	Box 96, Santa Rosa	Senate Chamber
Swing, Ralph E.	Attorney	R-D	36	San Bernardino	311 Central Bldg., San Bernardino	Senate Chamber
Tickle, Edward H.	Hotel, Real Estate	R-D	25	Monterey, San Benito	Carmel	Senate Chamber
Wagy, J. I.	Rancher	R-D	34	Kern	1909 2d Street, Bakersfield	Senate Chamber
Westover, Harry C.	Attorney	D	35	Orange	Bldrs.' Exch. Bldg., Santa Ana	Senate Chamber

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Venereal Diseases
(Twelve Bills)

A. B. 32, by Hawkins (referred to Committee on Public Health and Quarantine). Provides for premarital examinations.

A. B. 106, by Redwine, Kellems, Poulson, Stream, Corwin, Kepple, Waters, Bashore, Knight, Allen, Doyle, Pelletier, Daley and Eleanor Miller (referred to Committee on Medical and Dental Laws). Provides for premarital examinations for syphilis.

A. B. 490, by Hugh M. Burns, Heisinger, Garland, Corwin, Kepple, Dilworth, Kilpatrick, Redwine, Knight, Miss Miller and Mrs. Daley (referred to Committee on Public Health and Quarantine). Provides for prenatal examinations for syphilis.

A. B. 492, by same authors as A. B. 490 (referred to Committee on Governmental Efficiency and Economy). Provides for prenatal examinations for syphilis.

A. B. 493, by same authors as A. B. 490 (referred to Committee on Medical and Dental Laws). Provides for prenatal examinations for syphilis.

A. B. 831, by Tenney, Allen, Evans and Atkinson (referred to Committee on Medical and Dental Laws. An act to require serological blood tests for syphilis of pregnant women.

S. B. 79, by Kenny and Fletcher, by request (referred to Committee on Judiciary). Premarital examinations for venereal diseases.

S. B. 80, by Kenny and Fletcher, by request (referred to Committee on Public Health and Quarantine). Prenatal examination for syphilis.

S. B. 130, by Fletcher, Biggar, and Kenny (referred to Committee on Public Health and Quarantine). Prenatal examinations for syphilis.

S. B. 173, by Fletcher, Biggar, and Kenny (referred to Committee on Public Health and Quarantine). Premarital examinations for syphilis.

S. B. 767 and S. B. 768, by Law (referred to Committee on Prisons and Reformatories). Relates to prisoners suffering from venereal diseases.

Vital Statistics
(Eight Bills)

A. B. 431, 432, 546, 2011, 2012, 2129, 2703. S. B. 144.

X-ray
(One Bill)

S. B. 1183, by Carter (referred to Committee on Public Health and Quarantine). An act to safeguard the public health, to regulate the use of x-ray and x-ray appliances in connection with the examination of the jaws, teeth, alveolar process, gums and the immediate adjacent structures of living human beings, as an aid to the diagnosis and treatment of diseases and lesions pertaining thereto, to regulate the use, ownership and possession of x-ray appliances for said purposes; providing for the licensing of persons operating dental x-ray laboratories and x-ray appliances and setting up qualifications for such use.

Miscellaneous
(Seventeen Bills)

Medical Examinations of Persons Arrested for Driving Under the Influence of Intoxicating Liquors—A. B. 839, by Allen, Tenney, and Evans.

Blood Grouping Tests—A. B. 1246, by Redwine.

Blindness at Childbirth—A. B. 2764, by Johnson (by request).

Clinics and Dispensaries—S. B. 659, by Mixter and Foley.

Hospital and Medical Care for Students in State Colleges—A. B. 1815, by Robertson.

Jail Physicians—S. B. 676, by Garrison.

Laboratories—S. B. 292, by Slater.

Massage—A. B. 2585 and 2586, by Allen, by request.

Prophylactics—A. B. 2144, by Lyon. S. B. 601, by Westover.

Professional Standards—A. B. 2672, by Daley.

Surgical Supplies—A. B. 2436, by Call.

Trichinosis—A. B. 1704, by Johnson (by request).

Veterinary Medicine—A. B. 2413, by Corwin; S. B. 446, by Metzger; S. B. 977, by Phillips.

COMMITTEE ON PNEUMONIA CONTROL

Acting as a subcommittee to the standing California Medical Association Committee on Health and Public Instruction, the Committee on Pneumonia Control, Dr. Roy Thomas, Los Angeles, chairman, and Dr. William Shepard, San Francisco, secretary, has been making an earnest effort to forward its work. As an expression of its activities in Los Angeles County, the following item is reported concerning the educational film on pneumonia, entitled "A New Day." The item from the "Bulletin" of the Los Angeles County Medical Association follows:

Showing Film on Pneumonia

Enthusiastic coöperation is being offered by the Fox West Coast Theaters in the pneumonia educational campaign in Los Angeles County.

Some weeks ago the film, "A New Day," approved by the United States Department of Public Health, and produced in Hollywood by the Metropolitan Life Insurance Company, was viewed by the members of the Pneumonia Control Committee of the California Medical Association and by motion-picture representatives. The Los Angeles County Medical Association asked the theaters to coöperate in the campaign to end unnecessary pneumonia deaths.

The film, which was described in the last "Bulletin," is a dramatic story of the effectiveness of serum in the treatment of pneumonia.

All doctors are urged to see this film and to tell their patients and friends about it.

A schedule of the showing of this film follows:

Glendale

February 9-16—California Theater.
February 15-18—Capitol Theater.
February 24-28—Bards Theater.
March 19-21—Gateway Theater.
March 26 to April 1—Glendale Theater.

Van Nuys

February 12-14—Rivoli Theater.

Pasadena

February 8-14—Strand Theater.
February 15-21—Tower Theater.

South Pasadena

February 12-15—Ritz Theater.

Monrovia

February 11-14—Lyric Theater.

Los Angeles

February 12-16—Arroya Theater.
February 18-21—Starland Theater.

The film was shown last week in North Hollywood and other theaters in Van Nuys, Sherman Oaks, Pasadena, South Pasadena, and in Los Angeles.

Appreciation is expressed to the motion-picture theaters for helping so greatly in such important work of public-health education.

CALIFORNIA TUBERCULOSIS ASSOCIATION 1939 ANNUAL MEETING

A new projection machine which makes it possible to project full sized x-ray plates directly from the film onto a motion picture screen will be demonstrated during the three-day annual meeting of the California Tuberculosis Association in Santa Cruz, April 13 to 15, according to the announcement of Dr. C. R. Howson, president of the association.

This new instrument, which is the first of its kind to be designed to use a 2,000-watt lamp, makes it possible for a large audience to study an original x-ray film with about the same measure of detail as provided by the ordinary viewing box for a group of three or four. The projector will be used for a special x-ray symposium to be held on Saturday afternoon, April 15. Chairman for this symposium will be Dr. Rolla G. Karshner.

Doctor Howson further stated that Dr. Bruce Douglas, tuberculosis controller of Detroit, will be the guest speaker at the meeting, discussing "Tuberculosis Control" as a part of the joint clinical and sociological session on Friday afternoon, April 14.

As a special feature of the annual meeting, a Pacific Coast Post Seal Sale Conference will be conducted by Mr. Charles L. Newcomb, Seal Sale Director for the National Tuberculosis Association, on Thursday afternoon, April 13. This conference will be of interest to all lay tuberculosis workers on the West Coast.

An outstanding program of interest to both physicians and public health workers has been arranged for the annual meeting by a committee consisting of Dr. Charles L. Ianne (chairman), Dr. Edward Hayes, Dr. Walter Brown, Dr. William G. Burkhard, and Doctor Howson, ex-officio member.

The Friday morning clinical section, for which Dr. William G. Burkhard has been named chairman, will deal with medical education in medical schools, postgraduate medical education and nursing education. The Saturday morning clinical section will discuss "Clinical Rehabilitation of Tuberculosis Patients as a Public Health Problem," with Dr. Harold Brunn as chairman. Papers on extrapleural pneumothorax, pneumonolysis, tracheobronchial tuberculosis and "The Limitation of Present Status of Chest Surgery" will be presented.

The Friday afternoon session will be a joint meeting of the clinical and sociological sections. Dr. Charles L. Ianne will be chairman, and the general subject will be "Tuberculosis: a Public Health Problem." Papers will be presented on case finding in schools, state institutions, hospitals, clinics and industry; on segregation by force for the examination of suspects; on the "Newer Interpretation of Old Diagnostic Procedures"; on "The Handling of Tuberculosis as a Communicable Disease in Hospitals and Clinics" and on tuberculosis control.

The two morning sociological sections will deal with the program of the state tuberculosis association on Friday morning, and school health on Saturday morning. This latter session, under the chairmanship of Dr. Walter H. Brown, promises to be of outstanding interest, especially to school groups as it will discuss both health supervision and health instruction.

The anual banquet will be held at 7 o'clock on Friday evening, at which time Dr. C. R. Howson will present the report of the president, Dr. Chesley Bush, will bring greetings from the National Tuberculosis Association, and an address will be presented by a speaker not as yet named.

The meeting will be held at the Casa del Rey Hotel in Santa Cruz, and will be the first three-day convention to be held by the California Tuberculosis Association since its Riverside meeting in 1937. Last year, the state association met for a business meeting only in conjunction with the Los Angeles convention of the National Tuberculosis Association.

Physicians as well as the lay public interested in the latest problems in tuberculosis control, treatment and prevention are welcome to attend. A sizeable meeting is anticipated, and early hotel reservations are suggested.

COUNTY SOCIETIES

CONTRA COSTA COUNTY

The regular monthly meeting of the Contra Costa Medical Society was held on Tuesday, February 14, at the Hotel Carquinez, Richmond.

The following program was presented: *Diseases of the Thyroid,* by Dr. Mayo H. Soley of the University of California Hospital. Doctor Soley's paper was discussed by Dr. U. S. Abbott of Richmond and Dr. Thomas Dozier of Antioch. C. E. Dietderich, *Secretary*.

HUMBOLDT COUNTY

The Humboldt County Medical Society met on Thursday evening, February 10, at the St. Joseph Hospital in Eureka. Dr. John S. Chain, Vice-President, presided in the absence of Dr. S. P. Burre.

Dr. Mayo H. Soley gave a very instructive talk on the *Treatment of Goiter*. He stressed some of the newer conceptions of therapy that have found their way in very few textbooks on the subject. The manner of selecting cases for x-ray treatment or surgery was explained. He also discussed the proper handling of patients before and after each type of treatment.

There was a good attendance, and his remarks were well received by the members. Many intelligent questions were asked and a lively discussion was entered into by most of the members present.

Mr. J. O. Thorpe, General Manager of the Intercoast Hospitalization Insurance Association, discussed the *Relationship of the Medical Profession to Hospital Insurance*.

The Ethics Committee, under the chairmanship of Dr. A. R. Watson, was instructed to draw up a new set of by-laws. Dr. C. C. Falk, Sr., suggested that a uniform fee schedule be adopted for this county and a committee, headed by Dr. W. J. Quinn, was appointed to work out a solution to this problem. J. S. Woolford, *Secretary*.

SACRAMENTO COUNTY

The regular annual business meeting of the Sacramento Society for Medical Improvement was called to order by the president, Dr. Dave Dozier, at the Auditorium, on December 20. There were fifty-five members and guests present.

The report of the Board of Directors was read by the President. The financial and membership report of the Secretary was read and approved.

A motion was made by Doctor Kanner that the assessment for 1939 be the same as last year, namely, $15. The motion passed unanimously.

Doctor Scatena discussed some phases of the *New Health Insurance Program* being formulated by the California Medical Association.

The following were nominated and elected to the Board of Directors for the year 1939: Drs. M. L. Azevedo, H. M. Kanner, George Briggs, Ralph C. Teall, H. F. Schulter, E. S. Babcock, R. M. Wallerius, Norris Jones, W. Pollock.

Nominations were made for California Medical Association delegates to replace Dr. F. MacDonald and for alternates to replace Dr. Wayne Pollock. Both were reëlected.

Dr. G. E. Millar was nominated and elected to the office of secretary-treasurer for 1939.

G. E. Millar, *Secretary-Treasurer*.

SAN BERNARDINO COUNTY

The January meeting of the San Bernardino County Medical Society was held at the San Bernardino County Charity Hospital in San Bernardino on Tuesday, January 3. About seventy members and guests were present.

The application for membership of Dr. Herbert P. Nottage of Ontario was favorably voted upon.

Dr. A. D. Neubert reported on the special meeting of the House of Delegates of the California Medical Association, held in Los Angeles, to consider the prepayment plan for medical care.

Dr. Arnold H. Gegel of Los Angeles addressed the Society on *Résumé of the Latest Developments in the Care of Goiter,* as presented at the Third International Goiter Conference.

The discussion was opened by Dr. John L. Nevin of San Bernardino. Considerable general discussion and questions followed.

The meeting adjourned at 10 p. m., following which refreshments were served.

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The February meeting of the San Bernardino County Medical Society was held at the San Bernardino County Charity Hospital in San Bernardino on Tuesday, February 7.

In the absence of the President and two Vice-Presidents, Dr. Walter Cherry called the meeting to order at 8 p. m. About sixty-five members and guests were present.

It was moved, and seconded, that the following applications for membership be approved: Dr. C. A. Herrmann, Chino; Dr. Thomas E. Puthoff, San Bernardino; Dr. C. T. Halburg and Dr. William G. Patton, both of Redlands. The motion passed.

Mrs. Gabrielle Mulvane spoke briefly on behalf of the *Nursing Practice Act* and asked the support of the Society members.

The program of the evening was as follows: *The Diagnosis of Syphilis in General Practice,* by Dr. F. F. Abbott (colored lantern slides); *Standard Treatment of Syphilis,* by Dr. Paul Foster of Los Angeles; and *Dangers of Antiluetic Treatment,* by Dr. Fletcher Hall of Los Angeles.

Discussion opened by Dr. James W. Moreland of San Bernardino. Arthur E. Varden, *Secretary*.

SAN MATEO COUNTY

The meeting of the San Mateo County Medical Society was held on Wednesday, January 25, at the Benjamin Franklin Hotel. Dr. N. D. Morrison presided.

The Chairman announced that, with the consent of the San Francisco County Medical Society, Dr. E. W. Cleary had made an application for active membership by transfer. A motion was made, seconded and carried that Doctor Cleary be elected to active membership of this Society. The Chairman announced the election, to associate membership, of Dr. James K. Hazel. An announcement was made by the Chairman that an application for membership had been received from Dr. William R. Jepson.

The Chairman introduced Mrs. Opal Fennel, who gave a report on the *San Mateo County Chapter of the American Red Cross* for the past year. Further remarks were made by Mrs. Helen Cheseborough and Mrs. Howard. In her report, Mrs. Fennell expressed hope that the doctors would favorably endorse the proposed Nursing Practice Act to be acted upon by the Legislature.

The Secretary read the financial report for 1938. A motion was made, seconded and carried, that the report be approved.

The Secretary announced that a letter had been received from the State Association relative to Postgraduate Conferences. He suggested that in lieu of the formal Postgraduate Conference, a short series of lectures be provided on some subject of interest. This suggestion was approved unanimously.

The Secretary read a letter from the California Medical Association concerning the proposed Nursing Practice Act, and suggested that the Society and its members refrain from endorsing this bill until further information had been received from the State Association.

A letter from the Veterans' Administration Facility in Palo Alto, inviting the Society to hold a joint meeting with their society in April, was read. This was unanimously approved.

A letter of thanks for their Christmas gift from the Mills Hospital nurses was read.

The Secretary made an announcement concerning a pathological conference to be held at the annual session of the California Medical Association in Del Monte, to which the general practitioners are invited.

An announcement was also made concerning the desire of the Committee on Scientific Work of the California Medical Association to have photographs of physicians' offices to be exhibited at the annual meeting of the California Medical Association.

The Secretary made a report on a matter which had been submitted to him concerning the recommendation of physicians by school nurses, with particular reference to eye examinations. The matter had been precipitated when a school nurse submitted to a child's parents the names of physicians in the community who were practicing eye work and did not submit a list of optometrists. The Secretary submitted a verbal opinion from Doctor Schaupp, Chairman of the Council of the California Medical Association, to the effect that "school nurses are supposed to recommend physicians for health defects in children." The Secretary also mentioned the fact that the local optometrists had offered free examination of school children in the San Mateo schools. On motion, duly made, seconded and unanimously carried, the Secretary was directed to write a letter to the Board of Education and state therein that the County Medical Society was opposed to the mass examinations of children's eyes conducted in the schools by optometrists for commercial purposes. The letter was further to state that the County Society recommended that the school nurses refer all children with special defects to their family physician, from whom advice could be obtained concerning appropriate care for these defects.

The Chairman introduced Dr. Edwin Schultz of the department of bacteriology at Stanford University, who gave a very interesting talk on the subject of *Virus Infection, with Especial Reference to Poliomyelitis.* Doctor Schultz's talk was supplemented by a demonstration of lantern slides, including some colored slides of beautifully stained specimens, demonstrating the histology in poliomyelitis. Doctor Schultz's talk and demonstration were enthusiastically received.

J. Garwood Bridgman, *Secretary.*

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SAN JOAQUIN COUNTY

The regular meeting of the San Joaquin County Medical Society was held in the Medico-Dental clubrooms in Stockton on February 2. The meeting was preceded by the customary supper meeting at the Hotel Wolf, at which there were twenty-four members present. The paper of the evening was presented by Dr. George H. Sanderson, who spoke on the *Recent Academy of Orthopedic Surgeons at Memphis, Tennessee.*

The regular meeting was called to order by President Neill P. Johnson at 8:20 p. m.

The applications of Doctors L. B. Saslaw and E. L. Blackmun, Jr., being reported on favorably by the California Medical Association and the Membership Committee, and there being no objections from the floor, they were declared elected to membership. Dr. W. W. Fitzgerald, Chairman of the Finance Committee, reported on the solvency of the local society and suggested that members pay their dues promptly. Dr. C. A. Broaddus presented several certificates to newly elected members of the Medical Academy of Graduate Study.

The paper of the evening was read by Sidney Olsen of the University of California, who spoke on *Urinary Lithiasis.* This paper was illustrated by lantern slides and films. The paper occasioned considerable discussion from the floor.

There being no further business to come before the Society, the meeting was declared adjourned at 10 p. m. and refreshments were served.

G. H. Rohracher, *Secretary.*

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SANTA BARBARA COUNTY

The regular monthly meeting of the Santa Barbara County Medical Society was held in the Bissell Memorial Auditorium at 8 p. m. on February 13, 1939.

The subject for the evening's discussion was *The Surgery of Pulmonary Tuberculosis.* Dr. Samuel Robinson opened the program with a discussion of the value of collapse therapy in pulmonary tuberculosis and also discussed the advantages and disadvantages of the eight possible methods of collapsing the lung. Dr. Bruce Steele next discussed the history of, indications for, and results of pneumothorax. Dr. Irving Wills discussed thoroscopy and intrapleural apicolysis. Dr. E. L. Markthaler discussed the indications, contraindications, and results of phrenicectomy. Dr. Harry Henderson discussed pneumoperitoneum. Each of these discussions, except the opening one, was illustrated by drawings and lantern slides. Dr. Samuel Robinson closed the symposium with a detailed discussion of the Sauerbruck type of thoracoplasty, extrapleural apicolysis, and extrafascial apicolysis. This talk was illustrated by lantern slides and a demonstration of patients on whom these various procedures had been carried out. This symposium was discussed by Doctors Gates, Clark, Main, Cohn, and Ullmann. The discussion was closed by Doctors Robinson and Steele.

At the business portion of the meeting a resolution favoring the proposed *Nursing Practice Act* was introduced. Doctor Ullmann made a motion, seconded by Doctor Means and unanimously carried, that this resolution be laid on the table until we have a report from the Legislative Committee of the California Medical Association.

A motion was made by Doctor Clark that the Santa Barbara County Medical Society go on record as recommending that all milk used in hospitals in the county be pasteurized. This motion was seconded by Doctor Ullmann. It was discussed by Doctors Heiges, Main, and Means, and unanimously passed. D. H. McNamara, *Secretary.*

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YUBA-SUTTER COUNTY

The meeting of the Yuba-Sutter County Medical Society was held at the Rideout Memorial Hospital. Mr. and Mrs. G. Waite Curtis were hosts at a dinner to the Society prior to the scientific program and business meeting.

Delegations from both the Sutter County Tuberculosis Association and the Yuba County Tuberculosis Association met with the Society to work out a plan whereby the Tuberculosis Associations and the local Medical Society would be able to function together and facilitate the work in using the approximately $3,000 on hand for this work to the best advantage.

President P. E. Thunen appointed Dr. P. B. Hoffman and Dr. B. F. Miller, giving Doctor Hoffman the power to choose a third member to work with them and the committees of the two Tuberculosis Associations.

Dr. Chauncey D. Leake, of the chair of pharmacology of the University of California, spoke on the *Physiochemistry and Pharmacology of Sterols.* He named and classified the various sterols, giving their characteristic actions, therapeutics, and toxicology.

The outstanding examples which he discussed were the alkaloidal preparations of opium and related substances, and vitamin D and its many components.

He discussed cancer-producing sterols which, except for their nature, in effect are very closely related to recognized therapeutic sterols.

Doctor Leake, admonished the Society against the too free use of proprietary agents and drugs and strongly urged the strict adherence to the use of the United States Pharmacopeia. He also made a very positive statement regarding the use of pain-killing drugs, stating that in pain from traumatic injury, opiate derivatives are indicated, but where the pain is caused by swelling and edema of the tissues the coal-tar preparations are superior in alleviation of the pain, and the danger of drug addiction is nil. Doctor Leake, further discussed other sterol and near-sterol substances, such as the sex hormone, the cardiac glucocides, and the adrenal cortex hormone.

With the exception of two members, the entire society was present to hear Doctor Leake's talk.

President P. E. Thunen appointed the 1939 Board of Censors as follows: Drs. Francis P. Wisner, Leon M. Swift, and Romayne B. Whitney.

The meeting was adjourned until March 7.

Leon M. Swift, *Secretary.*

CHANGES IN MEMBERSHIP

New Members (119)

Alameda County

C. J. Attwood
James A. Barr
J. Emmet Clark
Gilbert W. Dygert
Rudolph D. Joldersma
Henry J. Kraaymes
William Clifford Pruitt
C. Ronald Smith

Fresno County

Florence A. Brown
Norman L. Knott
Raymond W. Norberg

Kern County

Dee L. Abbott
Ruth H. Hubbert
Jack A. Lighthill

Los Angeles County

David S. Alpert
Marden A. Alsberge
Gaston J. Baus
Oscar J. Blosmo
William C. Bradbury
Carl G. Bretthauer
Leo Buerger
Ralph V. Byrne
James P. Carmody
Charles B. Coggin
Joseph W. Dassett
Vernon S. Downs
Bertha Ehlers
George W. Elerding
Charles A. Foulks
Ernst Freund
Julian Ginsberg
Clarence H. Godard
Charles E. Greeley
Paul O. Greeley
Howard E. Harper
R. Fell Hosmer
Leland R. House
Patrick C. Humphreys
James Buford Johnson
Evan M. Jones
Robert A. Kennedy
Stuart D. King
W. A. Kirstensen
Joseph H. Marcus
Howard A. Mendelsohn
John A. Moffitt
Martin A. Mortensen
Claude K. Movius
Harold Nichols Mozar
Robert Null
James C. Ogden
Owen S. Parrett
Augustus G. Pohlman
Kathryn Redus
Arthur E. T. Rogers
Layton Rogers
May E. Romm
Alice Schiff-Goldstein
Felix H. Schubert
Alfred J. Scott
Nelson Warren Sheley
J. R. Silverthorn
John Lawrence Smith
John F. Snedaker, Jr.
M. L. Steckel
Ian D. Tiedemann
Samuel J. Walker
Leslie C. Watson
F. C. Westerhout
Thomas W. Whittaker
Warren Andrew Wilson
Orville O. Witherbee
Arthur V. Wortman

Mendocino County

E. H. Sawyer

Orange County

George C. Bergman
Arthur C. Elliott
L. J. Hannon
A. G. Hughes
Lucius F. Laverty, Jr.
Ralph E. White

Placer County

Earle A. Casey

Riverside County

H. M. Kelly
L. S. McLean
E. N. Mathis
Ralph E. Pawley

San Bernardino County

Mary Craig McClellan
Joseph P. O'Connor
Thomas Eugene Puthoff
Vernon Ormond Stahl

San Diego County

S. H. Savage

San Francisco County

Einar V. Blak
F. Edwyn Garfinkle
Emmett E. Henderson
David Kadesky
John H. Lawrence
James Ownby, Jr.
Theo Pavlides
Ralph Rosenberg
David E. Stafford

San Joaquin County

E. L. Blackmun, Jr.
L. B. Saslaw

San Luis Obispo County

Edward J. Maher

Shasta County

Evan G. Gamett

Solano County

A. Frank Brewer
Middleton Stansbury

Sonoma County

Roy Paul Woodruff

Stanislaus County

Paul H. Cronenwett

Tehama County

J. H. Belyea

Tulare County

Fred F. G. DeBusk
Robert Hardin
William S. Ireton
Ellis D. Sox
Wiley Carl Zink

Ventura County

Clyde R. Bennett
Thomas M. Fullenlove
Robert K. Harker

Yolo-Colusa-Glenn County

John W. Scott

Yuba-Sutter County

Irving W. Higgins
Samuel A. Morris

Transferred (8)

Alton C. Atwood, from Merced County to San Luis Obispo County.

Helen E. Bruckman, from Santa Clara County to Ventura County.

Charles W. Leach, from Yolo-Colusa-Glenn County to San Francisco County.

Arnold Manor, from San Francisco County to Monterey County.

Theodore K. Miller, from San Bernardino County to Ventura County.

Emilio J. Palomeque, from San Diego County to Los Angeles County.

Marshall Porter, from Ventura County to Mendocino County.

Leslie D. Trott, from Orange County to Los Angeles County.

Resigned (3)

Percy F. McMurdo, from San Francisco County.
John F. Renshaw, from Los Angeles County.
George C. Sabichi, from Los Angeles County.

In Memoriam

Drucks, Edward Sax. Died at Oakland, January 9, 1939, age 56. Graduate of the College of Physicians and Surgeons, San Francisco, 1907. Licensed in California in 1909. Doctor Drucks was a member of the Alameda County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

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Hawkins, Charles Lewis. Died at Bakersfield, January 14, 1939, age 68. Graduate of Jefferson Medical College of Philadelphia, 1900. Licensed in California in 1922. Doctor Hawkins was a member of the Kern County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

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Henke, George Benjamin. Died at Ontario, January 25, 1939, age 54. Graduate of Hahnemann Medical College of the Pacific, San Francisco, 1913, and licensed in California the same year. Doctor Henke was a member of the San Bernardino County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

✠

McClenahan, Henry Corbin. Died at San Francisco, December 10, 1938, age 68. Graduate of Tulane University of Louisiana School of Medicine, New Orleans, 1895. Licensed in California in 1906. Doctor McClenahan was a retired member of the San Francisco County Medical Society, the California Medical Association, and the American Medical Association.

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Newkirk, Harris Dana. Died at Minneapolis, Minnesota, December 31, 1938, age 60. Graduate of the University of Minnesota College of Homeopathic Medicine and Surgery, Minneapolis, 1903. Licensed in California in 1919. Doctor Newkirk was a member of the Orange County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

✠

Smith, Richard Cecil. Died at Superior, Wisconsin, October 30, 1938, age 53. Graduate of the Washington University School of Medicine, St. Louis, 1911. Licensed in California in 1916. Doctor Smith was a member of the Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

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OBITUARY

Frank Holmes Smith

1879–1938

In the rush and hurry of our everyday lives there occasionally come moments when remembrance bids us pause and turn our thoughts back to some sorrow or joy which was with us some time in the past. Such a moment came to us the other day and we feel that it is not inappropriate for us to dedicate a few thoughts to the memory of one who was loved by us all, and whose passing just one year ago this month, left an ache in our hearts which will be long in healing.

Too seldom in this life does it become our privilege to have the acquaintance of a man as universally admired as Frank Holmes Smith. Devoted to the highest ideals of his profession, he enjoyed the fond respect of his contemporaries, both young and old. His wide experience in the practice of medicine was being continually fortified by virtue of his seeking for the latest knowledge to be gleaned from medical literature. Few men of his generation could be held in more esteem by their younger colleagues.

We shall not soon forget his jovial wit, nor the kindliness of his nature. His personality may perhaps best be characterized by the image which will always be most vivid in our memory—a tall smiling figure in a black bowler hat, smoking the inevitable cigar, and carrying an armful of flowers for the table in the hospital library. Good humor and friendliness followed him wherever he went.

Loved by his patients and revered by his friends, he left us with the knowledge that our lives were somehow richer through knowing him. And so, on this first anniversary of his death, it is fitting that we let Memory hold us by the hand for a moment, so we may turn and wave one last farewell to this kindest of men, Frank Holmes Smith. Peace rest his soul.

THE WOMAN'S AUXILIARY TO THE CALIFORNIA MEDICAL ASSOCIATION†

MRS. CLIFFORD A. WRIGHT..............................President
MRS. FRED H. ZUMWALT..............Chairman on Publicity
MRS. FRANK H. RODIN..Assistant Chairman on Publicity

Official Notices

A Visitor from the National Auxiliary.—Mrs. Charles A. Tomlinson of Omaha, Nebraska, President of the Woman's Auxiliary to the American Medical Association, visited in San Francisco during the State Board Meeting, held February 17.

Mrs. Tomlinson shared honors with Mrs. Clifford A. Wright, President of the State Auxiliary and the State Board members at a tea in the afternoon of February 17, given by the Board of Directors of the San Francisco Auxiliary.

Mrs. E. J. Morrissey, Chairman of Arrangements, and her committee, graciously welcomed the guests at the home of the San Francisco County Medical Society. Mrs. J. C. Geiger, a member of the National and State Boards, and Mrs. William W. Newman, poured the tea, while Misses Horner and Gibson and Mrs. Douglas Tesky, the lovely daughters of Auxiliary members, dressed in formal afternoon gowns, served the guests.

Beautiful spring blossoms decorated the tea table and were in evidence everywhere.

Meeting of State Board of Directors.—The spring meeting of the officers and Board of Directors of the Woman's Auxiliary to the California Medical Association was held Friday, February 17, at the Fairmont Hotel.

The President, Mrs. Clifford A Wright, presided with the following officers and members of the Board and visiting County Presidents in attendance: Mrs. Frederick N. Scatena, president-elect; Mrs. A. E. Anderson, first vice-president; Mrs. George Calvin, second vice-president; Mrs. G. Wendell Olson, recording secretary; Mrs. E. Eric Larson, corresponding secretary; and Mrs. Harry O. Hund, treasurer.

Councilors at large: Mesdames Arthur T. Newcomb and Fred H. Zumwalt.

District councilors: Mesdames F. G. Lindemulder, J. R. Walker, Lawrence M. Knox, J. C. Geiger, Harold Trimble, and Robert M. Furlong.

County presidents: Mesdames Frank Baxter, Alameda; N. T. Enloe, Butte; C. N. Vanderberg, Fresno; Bernard J. Conroy, Marin; Garth Parker, and A. A. Arehart (publicity chairman), Monterey; George Spencer, Sacramento; Thomas E. Gibson, San Francisco; C. R. Kennedy, San Luis Obispo; J. C. Bridgman (publicity chairman), San Mateo.

After a busy morning session, the State Board and guests recessed for lunch.

Mrs. F. D. Fellows of San Francisco was in charge of reservations and arrangements, assisted by Mesdames John Humber and Thomas E. Gibson.

After luncheon, Mrs. Thomas E. Gibson, President of the San Francisco Auxiliary, presented the honored guest, the National President of the Woman's Auxiliary to the American Medical Association, Mrs. Charles A. Tomlinson, who is no stranger to the members of the California Auxiliary.

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† As county auxiliaries of the Woman's Auxiliary to the California Medical Association are formed, the names of their officers should be forwarded to Mrs. Frank H. Rodin, Assistant Chairman of the Publicity and Publications Committee, 2457 Bay Street, San Francisco. Brief reports of county auxiliary meetings will be welcomed by Mrs. Rodin and must be sent to her before publication takes place in this column. For lists of state and county officers, see advertising page 6. The Council of the California Medical Association has instructed the Editor to allocate two pages in every issue to Woman's Auxiliary notes.

She is well remembered for her gracious manner and inspiring messages given to the Auxiliary members at the Convention of the American Medical Association, held in San Francisco last June. Again Mrs. Tomlinson inspired her listeners regarding the activities of the Auxiliary and the importance of its place in the County, State and Nation.

Mrs. Gibson also called on Mrs. Wright, who responded with an interesting talk on the importance of friendliness and coöperation as the key to a successful auxiliary.

The afternoon session was called to order by the President, Mrs. Wright and interesting reports were given by members of the Board.

It was proposed by Mrs. Harold Trimble, Councilor from Seventh District, that a revision be made in the Constitution of the Woman's Auxiliary to the California Medical Association in Section 1 of Article IX—Nominations and Elections.

Article XV—Amendments—provides that:

> This Constitution may be amended at any regular annual meeting of this Auxiliary by a two-thirds vote of the members of the House of Delegates present and voting, provided a copy of the proposed amendment shall have been mailed to each member of the Board of Directors and to the Secretary of each County Auxiliary at least sixty (60) days prior to the date of said meeting; and provided further that said amendment shall have been published at least once in CALIFORNIA AND WESTERN MEDICINE at least three months prior to the adoption thereof; and provided finally that such amendment shall, prior to the adoption thereof, have been approved by the Council of the California Medical Association evidenced by resolution thereof.

The following proposed amendment is published as provided for in Article XV—Amendments:

> SECTION 1. For the years 1939 to 1940 and 1940 to 1941 the Nominating Committees, each consisting of five members, shall be elected at the Annual Meeting, held in May, 1939. Each committee shall consist of five members, two of whom shall be elected by the Board of Directors, and three to be members at large, elected by the House of Delegates. The members elected by the Board of Directors shall be elected at the regular meeting held previous to the Annual Meeting, while the members elected by the House of Delegates shall be elected at the first session of the Annual Convention. The Board of Directors shall designate the chairman of each committee. The Nominating Committee so elected for 1939 to 1940 shall present this report of nominees as soon as possible. The Nominating Committee so elected for 1940 to 1941 shall meet sixty days prior to the Annual Meeting of 1940 and prepare its report and submit the same at the first session of the Annual Meeting in 1940.
>
> Beginning with the Annual Meeting in 1940, and annually thereafter, the Nominating Committee shall be elected each year in advance and shall consist of five members, two elected by the Board of Directors and three to be members at large, elected by the House of Delegates.
>
> It shall be the duty of the Nominating Committee to nominate and present, in the regular order of business, candidates for the following offices: President-elect, first vice-president, second vice-president, recording secretary, treasurer and four councilors-at-large, to serve for one year or until their successors assume office.

Section 1 of Article IX at present provides as follows:

> A Nominating Committee, consisting of five members, shall be provided as follows: Two members to be elected by the Board of Directors at the regular meeting held previous to the annual meeting, and three members at large, to be elected by the House of Delegates at the first session of the annual convention. The Board of Directors shall designate the chairman. It shall be the duty of this committee to nominate and present in the regular order of business, candidates for the following offices: President-elect, first vice-president, second vice-president, recording secretary, treasurer and four councilors-at-large, to serve for one year or until their successors assume office.

Component County Auxiliaries

Alameda County

Mrs. A. A. Alexander of Piedmont was chairman of arrangements of the annual dinner dance given by the Woman's Auxiliary to the Alameda County Medical Association honoring their husbands, the doctors of Alameda County, on February 15.

The Athens Athletic Club was the scene of the gala spring party, which provided an excellent floor show, bridge, Chinese checkers, and "just visiting" in the lounge of the club.

The guests were graciously received by the Reception Committee and dinner was served at 8 p. m. to over three hundred doctors and wives.

Spring was the theme for the decorations used by Mrs. Wallace T. Partch and her committee in the lounge and on the dinner tables.

Mrs. I. O. Church was chairman of entertainment, assisted by Mrs. Walter Adams, who was in charge of games.

Reservations were made with Mrs. George Calvin.

MRS. GRANT ELLIS, *Publicity Chairman.*

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Fresno County

The Woman's Auxiliary to the Fresno County Medical Association were happy to welcome Mrs. Harold G. Trimble of Piedmont, Councilor for Seventh District and State Hygeia Chairman, at their meeting on February 7. Thirty members were present.

Mrs. Trimble spoke on the *Value and Purpose of the Hygeia Health Magazine to the General Public Through a Wide Circulation.* She also gave splendid ideas on the ways and means of developing the circulation. Her inspiring talk created much enthusiasm among the members.

Mrs. Kenneth Staniford presented Dr. Elliot Sorsky, who gave a talk on the *Comparison of Health Conditions in India with Those in America.* He illustrated his talk with colored movies, which were very instructive and entertaining.

Heart Disease will be the topic for discussion at a public health meeting on March 10. Mrs. J. R. Walker is chairman, and is developing an interesting program.

MRS. CHARLES H. INGRAM, *Publicity Chairman.*

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Los Angeles County

The regular monthly meeting of the Los Angeles County Woman's Auxiliary was held at the Orthopedic Hospital on January 24. Luncheon was served promptly at noon to 136 members and guests.

After luncheon, the President, Mrs. William H. Leake, called the meeting to order. Reports were given by the Treasurer and standing committees.

Mrs. Leake requested the members to convey to her personally their ideas of *The Courier.*

Dr. Charles L. Lowman, Chief of Staff of the Orthopedic Hospital, welcomed the members and guests of the Auxiliary with a short address. Mrs. Leake also introduced Mrs. Weir, coördinator of Educational Activity, and Miss Berry, assistant superintendent of the hospital.

Dr. Robert L. Carroll, a member of the hospital staff, described a very interesting and beneficial Educational Activity provided for the patients, which he calls *The Therapeutic Theatre.* Any patient may join the orthopedic drama group regardless of deformity, and the results are extremely satisfactory.

Mrs. Tyrone Power directed the well-written play, entitled "For Distinguished Service Under Fire." A story dealing with the eternal triangle in the lighter vein.

One of the guests of honor, Mme. Gosta Dohlman, wife of Professor Dohlman of Lund University, Sweden, was generous in her praise of Southern California. She compared its beauty and charms with those of Sweden. Mme. Dohlman pointed out that although her country was not very rich, indigent persons were well cared for by the government.

MRS. KARL VON HAGEN, *Publicity Chairman.*

Orange County

The doctors' wives and members of the Woman's Auxiliary joined in the celebration of the fifty years of organized activity of the Orange County Medical Association at their annual installation and banquet, given January 10, at the Santa Ana Country Club.

A string trio furnished music before and during the dinner hour. Cantu, a magician from Mexico City, entertained the guests with feats of magic.

Greetings from the Woman's Auxiliary were extended by the President, Mrs. Hiram Currey.

The guest speaker, Hon. Judge Franklin West, addressed the members on *Leaves From the Notebook of a Lawyer.*

MRS. G. WENDELL OLSSON, *Publicity Chairman.*

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Riverside County

The Riverside County Medical Association and the San Bernardino Medical Association were joined by the members of the Woman's Auxiliary of Riverside County for a banquet honoring the officers of the California Medical Association on January 18.

About 110 doctors and wives met at the Riverside Woman's Club. The guests of honor were State Officers: Doctors W. W. Roblee, president; Charles Dukes, president-elect; George Kress, secretary. Also the charming President of the State Auxiliary, Mrs. Clifford A. Wright and her secretary, Mrs. E. Eric Larson.

After dinner, the *Proposed Medical Service Plan* was discussed by Dr. Charles Dukes.

Later in the evening the doctors and the wives met separately, at which time Mrs. Wright addressed the women with a message of inspiration and interest.

Although the doctors' wives of San Bernardino County are not organized into an auxiliary, it was very gratifying and a great pleasure to have so many guests from that county. MRS. T. A. CARD, *Publicity Chairman.*

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San Diego County

The Woman's Auxiliary to the San Diego County Medical Association was honored January 10 by a visit from the State President, Mrs. Clifford A. Wright and her secretary, Mrs. E. Eric Larson.

An informal reception was held in the lounge of the University Club, followed by a luncheon at 12:30. Sixty-eight members were present.

In the absence of the President, Mrs. C. O. Tanner, the Vice-President, Mrs. R. Emerson Bond, presided.

Mrs. Wright gave a brief talk on the *Need of a Woman's Auxiliary in Imperial County* and enlisted the aid of the San Diego County Auxiliary in establishing one. Mrs. Wright also urged the use of books from the State Auxiliary library for book reviews and study. Mrs. Larson spoke a word of greeting to the members.

Mrs. F. G. Lindemulder, Chairman of Public Relations, gave a report of the Public Health Institute, held November 1. Mrs. E. H. Christopherson, chairman of the annual bridge benefit given on November 14, reported on the activity. MRS. H. K. ALBERTSON, *Publicity Chairman.*

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San Francisco County

The regular monthly meeting of the Woman's Auxiliary to the San Francisco County Medical Society was held January 17 in the County Medical Society Building. The president, Mrs. Thomas E. Gibson, presided with over one hundred members and guests present.

The guest speaker, Mrs. Frances Parish, gave a very interesting talk about her *Seeing-eye Dog.* She told of her experience and how she had obtained her dog. It was through listening to a radio broadcast by Mr. Alexander Wollcott on the Town Crier program that she learned of the service of the seeing-eye dog in assisting and caring for blind persons in their need for a guide. Mr. Wollcott assisted Mrs. Parish in obtaining her dog from the Society for Seeing-eye Dogs in Morristown, New Jersey, where this special breed are raised and trained.

After the meeting, tea was served in the library. Mesdames A. S. Musante and Harry Oliver, assisted by their committee, were the hostesses of the day. Spring blossoms were used in the beautiful decorations.

MRS. CLAIN F. GELSTON, *Publicity Chairman.*

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Santa Barbara County

A luncheon meeting of the Woman's Auxiliary to the Santa Barbara County Medical Society was held at the Colonial Tea Room, January 9, with seventeen members and one guest present.

The treasurer was authorized to notify the Superintendent of Nurses of the Knapp School of Nursing that the Auxiliary would make the customary award of $10 to the best student nurse in the graduating class of April, 1939.

Mrs. William Renfry Hunt reviewed William MacCarthey's book, "Fifty Years a Country Doctor."

The first vice-president, Mrs. Alfred Wilcox, invited members of the Woman's Auxiliary to attend a meeting of the American Association of University Women's Forum at her home, January 18. *Socialized Medicine* was the topic for discussion.

MRS. C. W. HENDERSON, *Publicity Chairman.*

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Santa Clara County

The regular January and February meetings of the Woman's Auxiliary to the Santa Clara Medical Association were held at Savin's Restaurant in San Jose, where the members met for luncheon.

Mrs. Russell V. Lee, program chairman, has followed the theme of Public Health and Public Health Laws this year and presented Dr. Edward Liston of Palo Alto at the January meeting. Dr. Liston talked on *Medical and Hospital Insurance* and reported on the House of Delegates meeting in Los Angeles. He explained that much had been accomplished and that there was still much to be worked out.

In February, Dr. Walter Brown, Professor of Hygiene at Stanford University, spoke on *Public Health, Past and Present.* Doctor Brown gave a very vivid picture of his recent trip to the Norwegian countries where he visited the leading public health centers, medical schools, and hospitals, and was invited to speak at these various institutions. He described Norway's method of controlling venereal disease and the tremendous program for the care of children's teeth which are in poor condition due to the lack of necessary vitamins in the average diet.

The members voted to send $5.00 to the County Tuberculosis Association and $5.00 for the *Courier.*

A silver tea is being planned to take place early in May at the home of Mrs. R. Stanley Kneeshaw, who is Chairman of Arrangements. The proceeds will be used to send as many children as possible to camp this summer.

MRS. CHARLES E. MOORE, *Publicity Chairman.*

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Santa Cruz County

The Woman's Auxiliary to the Santa Cruz County Medical Society met for luncheon at Buckhart's in Watsonville on January 23, with eighteen members present. The president, Mrs. Alfred L. Phillips, presided.

A very interesting and educational program on the *Cure and Prevention of Cancer* is being planned for April.

At the conclusion of the meeting, the members were taken on a tour of inspection of the beautiful new Watsonville Hospital. MRS. R. C. ALSBERG, *Publicity Chairman.*

MISCELLANY

Under this department are ordinarily grouped: News Items; Letters; Special Articles; Twenty-five Years Ago column; California Board of Medical Examiners; and other columns as occasion may warrant. Items for the News column must be furnished by the fifteenth of the preceding month. For Book Reviews, see index on the front cover, under Miscellany.

NEWS

Coming Meetings

American Medical Association, St. Louis, Missouri, May 15 to 19, 1939. Olin West, M. D., Secretary, 535 North Dearborn Street, Chicago, Illinois.

California Medical Association, Hotel Del Monte, May 1 to 4, 1939. George H. Kress, M. D., Secretary, 450 Sutter Street, San Francisco.

Pacific Coast Surgical Association, San Francisco, Oakland, Del Monte, March 28 to 31, 1939. H. Glenn Bell, M. D., Secretary, University of California Hospital, San Francisco.

Medical Broadcasts*

Los Angeles County Medical Association

The radio broadcast program for the Los Angeles County Medical Association for the month of March is as follows:

Thursday, March 2—KECA, 10:45 a. m., The Road of Health.
Saturday, March 4—KFI, 9:00 a. m., The Road of Health; KFAC, 11:30 a. m., Your Doctor and You.
Thursday, March 9—KECA, 10:45 a. m., The Road of Health.
Saturday, March 11—KFI, 8:00 a. m., The Road of Health; KFAC, 11:30 a. m., Your Doctor and You.
Thursday, March 16—KECA, 10:45 a. m., The Road of Health.
Saturday, March 18—KFI, 9:00 a. m., The Road of Health; KFAC, 11:30 a. m., Your Doctor and You.
Thursday, March 23—KECA, 10:45 a. m., The Road of Health.
Saturday, March 25—KFI, 9:00 a. m., The Road of Health; KFAC, 11:30 a. m., Your Doctor and You.
Thursday, March 30—KECA, 10:45 a. m., The Road to Health.

Health for the Masses—How?—In a series of articles, commencing on February 6, the San Francisco *News* presented an interesting series of articles, three of which were from the pen of Dr. T. Henshaw Kelly of San Francisco, who presented the story of Voluntary Medical Service and the newly organized California Physicians' Service. The foreword of the third article of the series follows:

"Should health insurance be on a compulsory or voluntary basis? This issue confronts Californians, with the State Administration sponsoring a compulsory health insurance bill, pending in the Legislature, and the California Physicians' Service, organized by the California Medical Association, announcing it is about to offer a state-wide voluntary health insurance. Having discussed the need for health insurance, and the steps already taken toward it, the *News* offers the views of proponents of each system: First, Dr. Barbara N. Armstrong, professor of law at the University of California, author and expert in the field of social security, presents the case for the Administration's bill, which she helped prepare, in a series of articles of which the following is the first. Next, Dr. T. Henshaw Kelly, assistant secretary-treasurer of the California Physicians' Service, will discuss the voluntary system.—The Editor."

Federal Income Tax Reports: Deductions.—A summary of possible deductions allowable for physicians appeared in California and Western Medicine, March, 1938, on page 228. Readers who are compiling their income tax reports may wish to refer to the article.

American Board of Obstetrics and Gynecology: Examinations.—Application for admission to the Group A, May, 1939, Board examinations must be on file in the Secretary's office not later than March 15, 1939.

The general oral, clinical and pathological examinations for all candidates, Part II Examinations (Groups A and B), will be conducted by the entire Board, meeting in St. Louis, Missouri, on May 15 and 16, 1939, immediately prior to the annual meeting of the American Medical Association. Notice of time and place of these examinations will be forwarded to all candidates well in advance of the examination dates.

Candidates for reëxamination in Part II (Groups A and B), must request such reëxamination by writing the Secretary's office before April 1, 1939. Candidates who are required to take reëxaminations must do so before the expiration of three years from the date of their first examination.

The annual dinner meeting of the Board to which all diplomates and candidates are invited, as well as their wives and others interested in the work of the Board, will be held at the Congress Hotel, St. Louis, on Wednesday evening, May 17, following the close of the examinations.

Application blanks and booklets of information may be obtained from Dr. Paul Titus, Secretary, 1015 Highland Building, Pittsburgh, (6) Pennsylvania.

The Samuel D. Gross Prize: Fifteen Hundred Dollars.—The conditions annexed by the testator are that the prize "shall be awarded every five years to the writer of the best original essay, not exceeding 150 printed pages, octavo, in length, illustrative of some subject in Surgical Pathology or Surgical Practice founded upon original investigations, the candidates for the prize to be American citizens."

It is expressly stipulated that the competitor who receives the prize shall publish his essay in book form, and that he shall deposit one copy of the work in the Samuel D. Gross Library of the Philadelphia Academy of Surgery, and that on the title page it shall be stated that to the essay was awarded the Samuel D. Gross Prize of the Philadelphia Academy of Surgery.

The essays, which must be written by a single author in the English language, should be sent to the "Trustees of the Samuel D. Gross Prize of the Philadelphia Academy of Surgery, care of the College of Physicians, 19 South Twenty-second Street, Philadelphia," on or before January 1, 1940.

Each essay must be typewritten, distinguished by a motto, and accompanied by a sealed envelope bearing the same motto, containing the name and address of the writer. No envelope will be opened except that which accompanies the successful essay.

The committee will return the unsuccessful essays if reclaimed by their respective writers, or their agents, within one year.

The committee reserves the right to make no award if the essays submitted are not considered worthy of the prize.

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* County societies giving medical broadcasts are requested to send information as soon as arranged (stating station, day, date and hour, and subject) to California and Western Medicine, 450 Sutter Street, San Francisco, for inclusion in this column.

Lawrence to Speak at National Physicians' Meet.—The work of the University of California cyclotron in producing radioactive substances and in the direct treatment of cancer through its neutron rays is to be made the subject of the convocation address of the annual meeting, American College of Physicians, in New Orleans. The address is to be made by Dr. E. O. Lawrence, director of the University's radiation laboratory. Dr. William J. Kerr, head of the department of medicine, in the University's Medical School, San Francisco, is president of the College. The meeting is to be held March 27 to 31.

Doctor Lawrence has selected for his topic, The Newer Physics and Medicine. He will go into the production of the radioactive substances and the neutron ray in some detail, and will touch on their application in the field of medicine from the viewpoint of the physicist solely.

Portland Postgraduate Course in Ophthalmology and Otolaryngology.—The Fourth Annual Spring Postgraduate Course in Ophthalmology and Otolaryngology will be held in Portland, Oregon, the week of April 3 to 8, 1939. It is announced that the course will be honored by the presence of two nationally known guest teachers for the full week. They are Dr. John J. Shea of Memphis, and Dr. Webb W. Weeks of New York. This course is sponsored jointly by the University of Oregon Medical School and the Oregon Academy of Ophthalmology and Otolaryngology. The program is a diversified one; mornings are occupied with didactic lectures, afternoons are devoted to clinical work and at the evening sessions there will be classes in the Department of Surgical Anatomy. Added features to this "fourth" course will be a course in cat's eye surgery given by Doctor Weeks, and Teaching Moving Pictures, which have proven so popular at the American Academy meetings.

The preliminary programs will be ready about March 1. These, and additional information can be secured by writing to Paul Bailey, Secretary, 929 Medical Dental Building, Portland, Oregon.

A New Treatment for Diphtheria and Lockjaw.—The use of a single agent designed to protect against the diseases of diphtheria and tetanus is being started by the department of pediatrics of the University of California Medical School as part of its disease prevention program. In the past, diphtheria prevention was first accomplished by the use of toxin-antitoxin mixtures. It was later shown that formalin could be used in place of the antitoxin and that the resultant preparation known as toxoid was not only more efficient as an immunizing agent, but also avoided the horse serum present in antitoxin.

More recently, Doctor Ramon, who first developed toxoid at the Pasteur Institute has shown that the same method can be applied to tetanus. While the toxoids of diphtheria and tetanus can be given separately, Doctor Ramon and others working in the field of immunology have shown that the combination of the two toxoids is of benefit.

Thus, an infant or a child with no more manipulation than is now done to protect against diphtheria, can also have the benefit of protection against tetanus. It is hoped the procedure may avoid for some sensitive individuals the hazard of tetanus antitoxin administration.

At the present time emergency hospitals use the antitoxin as a preventive measure against tetanus developing in injuries, particularly from street accidents. It is hoped that with the new program a final injection of toxoid for such individuals as have had the program will be more efficient and simpler.

The program has been adopted by the French Army and a few clinics in the United States. As a measure of considerable merit for public health a more extensive adoption can be anticipated.

Public Health League of California. — The annual meeting of the Northern District of the Public Health League of California was held on Thursday evening, February 9, at the Veneto Restaurant in San Francisco.

Bills now before the Legislature and the election of officers were the major items on the program.

Stanford University School of Medicine.—Stanford University is pleased to announce that the twenty-seventh course of Lane Lectures will be given by Dr. Thomas M. Rivers on May 22, 23, 24, 25, and 26, 1939. The general title for the series of lectures will be "Viruses and Virus Diseases."

Doctor Rivers is the director of the Hospital of the Rockefeller Institute for Medical Research, and is an international authority on virus diseases.

"Syphilis and Your Town."—"The cheapest thing any town can do with syphilis is to cure it."

That was the keynote of a recent announcement by Dr. R. A. Vonderlehr, Assistant Surgeon-General in charge of the Division of Venereal Diseases, United States Public Health Service, of a new nine-point program for syphilis control in the local community. The effort is a part of the Government's nation-wide campaign to check the spread of venereal diseases.

The program is outlined in a new publication, *Syphilis and Your Town,* designed to assist local communities in making an adequate check upon the scope, effectiveness and facilities of local venereal disease control projects. The nine points, set forth in a questionnaire intended to suggest best results from unified action by local groups, are as follows:

1. Do your state and town have a trained public health staff that knows how to deal with syphilis?
2. Does your state require reporting and follow-up on all cases of syphilis?
3. Are patients in your town assured of good syphilis treatment even if they cannot afford to pay?
4. Do physicians and clinics in your town have access to free laboratory service for blood tests?
5. Do your state and town distribute free antisyphilitic drugs to all physicians and clinics?
6. Is every expectant mother required to have a blood test in your state?
7. Are medical certificates, including a blood test for syphilis, required before marriage in your state?
8. Does every complete physical examination given in your town include the blood test?
9. Has your town an education program aimed at age groups most frequently acquiring syphilis?

Doctor Vonderlehr pointed out that public education is the crux of syphilis control, and added, "People must learn to consult a doctor or clinic. They must know that drugstore remedies and self-treatment are worthless. They must know that treatment begun early will cure syphilis in nearly every case, while, if left untreated, the patient is likely to develop brain, heart, or nervous system complications."

The Public Health Service stressed the value of the blood test and the importance of making this test a part of every complete physical examination. "Syphilis control programs," said the new publication, "should make provision for blood tests, not only for prenatal examination but as routine for every hospital patient and a part of every insurance examination. Life expectancy of untreated syphilitics is 20 per cent lower than normal."

Doctor Vonderlehr concluded by insisting that the public must realize the cost of syphilis—its share in lives wasted, its toll in dollars. "All this is preventable if adequate control programs can be started and continued in every part of the country," he declared. "It will be cheaper, too—the cheapest thing any town can do with syphilis is to cure it."

Southern California Medical Association.—The one-hundredth semi-annual meeting of the Southern California Medical Association will be held at the headquarters of the Los Angeles County Medical Association, 1925 Wilshire Boulevard, Los Angeles, Wednesday and Thursday, March 15 and 16, 1939. A splendid program of scientific papers and discussions has been arranged.

Commemorating the fiftieth anniversary of the Association, a semi-centennial celebration will be held on the evening of Wednesday, March 15, 1939, at seven o'clock, at the California Club. Following a semi-formal stag dinner, addresses will be made by a brilliant array of leaders of organized medicine.

All members of the county medical societies of Southern California are invited to attend the scientific meetings and the dinner program. Since it is anticipated that there will be a large attendance at the dinner, it will be necessary that reservations be made without delay. Covers will be laid only for those who have paid reservations. Checks in the sum of $2.50 per plate should be made payable to the Southern California Medical Association, and may be sent to Suite 501, 1930 Wilshire Boulevard, Los Angeles. On receipt of remittances, tickets, which will be numbered, will be forwarded without delay.

The program follows:

March 15

WEDNESDAY AFTERNOON SESSION

2 p. m.

Pneumonia—The Results of Specific Therapy in Cases Due to Pneumococci of the Higher Types.—Roy E. Thomas, M.D., Los Angeles.
Discussion by George T. Burke, M.D., Pasadena, and Louis E. Martin, M.D., Los Angeles.

Prophylactic Measures in Pernicious Anemia.—John Martin Askey, M.D., Los Angeles.
Discussion by William S. Kiskadden, M. D., and A. M. Roberts, M.D., both of Los Angeles.

Functional Indigestion as Related to Acidity of the Duodenal Contents.—Alfred E. Koehler, M.D., Santa Barbara.
Discussion by William C. Boeck, M.D., and Ernest C. Fishbaugh, M.D., both of Los Angeles.

Gout.—Philip S. Hench, M.D., Rochester, Minnesota.
Discussion by Joseph A. Pollia, M.D., and Ray A. Carter, M.D., both of Los Angeles.

The Relation of Medicine to Insurance.—William H. Scoins, M.D., Los Angeles.
Discussion by Verne R. Mason, M.D., and John C. Wilson, M.D., both of Los Angeles.

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March 15

Semicentennial Celebration on the occasion of the One Hundredth Semiannual Meeting of the Southern California Medical Association.

Dinner, Wednesday, March 15, 7 p. m., California Club, Los Angeles.

PROGRAM

Address of Welcome, John C. Ruddock, M.D., President
Toastmaster, Edward M. Pallette, M.D.

GUEST SPEAKERS

Philip S. Hench, M.D., Rochester, Minnesota; Associate Professor of Medicine, Mayo Foundation, University of Minnesota.

William W. Roblee, M.D., Riverside; President, California Medical Association.

William J. Kerr, M.D., San Francisco; Professor of Medicine, University of California; President, American College of Physicians; President, American Heart Association.

Donald C. Balfour, M.D., Rochester, Minnesota; Professor of Surgery, Mayo Foundation, University of Minnesota; Past President, American College of Surgeons; Regent, American College of Surgeons.

Rock Sleyster, M.D., Wauwatosa, Wisconsin; Medical Director, Milwaukee Sanitarium; President-elect, American Medical Association.

March 16

THURSDAY MORNING SESSION

10 a. m.

Late Results Following Operations on the Biliary Tract.—James H. Saint, M.D., Santa Barbara.
Discussion by Leroy B. Sherry, M.D., Pasadena, and Conrad J. Baumgartner, M.D., Los Angeles.

The Present Status of the Treatment of Fractures of the Neck of the Femur.—Francis M. McKeever, M.D., Los Angeles.
Discussion by Vernon P. Thompson, M. D., and Paul E. McMaster, M.D., both of Los Angeles.

Osteomyelitis of the Frontal Bone.—Joseph B. Stevens, M.D., Los Angeles.
Discussion by Pierre P. Violé, M.D., and J. Mackenzie Brown, M.D., both of Los Angeles.

The Management of Strabismus.—John P. Lordan, M.D., Los Angeles.
Discussion by M. N. Beigelman, M.D., and A. Ray Irvine, M.D., both of Los Angeles.

March 16

THURSDAY AFTERNOON SESSION

2 p. m.

Hypoglycemia with Special Reference to Adenoma of the Pancreas.—Hildahl I. Burtness, M.D., Santa Barbara.
Discussion by Percival A. Gray, M.D., Santa Barbara, and George Thomason, M.D., Los Angeles.

Sulfanilamide.—A. G. Bower, M.D., and William J. Mitchell, Jr., M.D., Los Angeles.
Discussion by A. Elmer Belt, M.D., Los Angeles, and Paul M. Hamilton, M.D., Alhambra.

Avitaminosis as Seen in Private Practice.—Arthur A. Marlow, M.D., La Jolla.
Discussion by Howard F. West, M.D., Los Angeles, and Benjamin N. Tager, M.D., West Los Angeles.

Urolithiasis and Protracted Recumbency.—Albert J. Scholl, M.D., Los Angeles.
Discussion by James A. May, M.D., San Diego, and Henry Verrill Findlay, M.D., Santa Barbara.

March 16

THURSDAY EVENING SESSION

Joint Meeting of the Southern California Medical Association with the Los Angeles County Medical Association.

The Social Aspects of Medicine.—Rock Sleyster, M.D., Wauwatosa, Wisconsin; Medical Director, Milwaukee Sanitarium; President-elect, American Medical Association.

Malaria Infection: Color Test for Blood Corpuscles.—A new and simple biochemical color test of blood corpuscles which promises to disclose a malaria infection when parasites cannot be found under the miscroscope has been devised by H. O. Proske, Chief Medical Technician, and Dr. Robert B. Watson, Senior Malariologist, Division of Malaria Studies and Control of the Tennessee Valley Authority and the technique of the new test method is described in a paper, "The Protein Tyrosin Reaction," in the current issue of *Public Health Reports* of the United States Public Health Service.

A diagnosis of malaria from clinical findings alone has sometimes proved to be inconclusive because some of its many symptoms are similar to those of other diseases. For this reason it is necessary to resort to the use of certain laboratory tests—such as the miscroscopic demonstration of malaria parasites in the red blood corpuscles or a specific pigment in certain white blood cells. This is not always easy to accomplish, however, particularly when the number of parasites in the blood circulation is small.

The new Proske-Watson test is based upon the fact that a certain fraction of the blood proteins, the euglobulins, is increased in most cases of malaria, and that this increase can be demonstrated by the color intensity developed by this protein.

No equipment other than is found in any clinical laboratory is necessary to perform this test, and the reagents employed may be purchased from clinical supply houses. Sterility of equipment is unnecessary. The only major precaution is that all glassware must be chemically clean.

In 1927, Henry described a seriodiagnostic test for malaria. This test was based on the assumption that malaria pigment is an active substance which either gives rise to the production of antibodies or imparts flocculating pecularities to the serum of malaria patients.

It has been suggested that a photometer be used in connection with the reading of the Henry test and its principal modifications. Since this instrument is expensive, the performance of the test has thus been limited to unusually well-equipped laboratories, a circumstance possibly accounting for the fact that the Henry test has not been much used in this country.

It was the purpose of Proske and Watson to devise a simpler and more accurate biochemical method for the quantitative estimation of serum euglobulin which would give results comparable to the melano-reaction of Henry and the distilled water method of Chlorine, obviate the necessity for the use of an expensive photometer, and be relatively easy to perform, so that it could be more generally adaptable for the diagnosis of malaria.

The originators of the new test, in a recent series of experiments, have obtained 97.4 per cent positive reactions in known malaria cases as compared with 81.9 per cent yielded by microscopic examination. The test is positive in a few other diseases, but these can be differentiated by specific tests.

Medical School, University of California: Alumni Day, March 22, 1939.—Commemorating the seventy-first charter anniversary of the University of California, the Medical School will celebrate its alumni day on Wednesday, March 22, 1939, at the University of California Hospital, Medical Center, San Francisco.

The program follows:

MORNING

Toland Hall

9:00 a.m. to 10:30 a.m.—Demonstration clinics, Division of Medicine.—Dr. William J. Kerr and staff.

10:30 a.m. to 11:15 a.m.—Demonstration clinics, Division of Surgery.—Dr. Howard C. Naffziger and staff.

11:15 a.m. to 11:30 a.m.—Intermission.

11:30 a.m. to 1:00 p.m.—Demonstration clinics, Division of Pediatrics.—Dr. Francis S. Smyth and staff.

Operating Rooms

9:00 a.m. to 1:00 p.m.—Operative clinics, Division of Surgery—Dr. Howard C. Naffziger and staff. Operative clinics, Division of Obstetrics and Gynecology.—Dr. Frank W. Lynch and staff.

Afternoon

2:30 p.m. to 4:00 p.m.—Tour of inspection of the Medical Center. Senior medical students will act as guides.

Annual Congress on Medical Education and Licensure.—The thirty-fifth session was held on February 13 and 14, at the Palmer House, Chicago.

The program follows:

MONDAY MORNING, 10:00

Ray Lyman Wilbur, M.D., Presiding

The Protection of the Public Through the Activities of the Council on Medical Education and Hospitals of the American Medical Association.—Ray Lyman Wilbur, M.D., LL.D., Chairman, Stanford University, Calif.

College Education for the Future Doctor.—James B. Conant, Ph.D., President, Harvard University, Cambridge, Mass.

The Organization and Subject Matter of General Education.—Robert Maynard Hutchins, LL.D., President, University of Chicago.

Canadian Experiments in Medical Economics.—T. C. Routley, M.D., LL.D., General Secretary, Canadian Medical Association, Toronto, Ont.

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MONDAY AFTERNOON, 2:15

Fred Moore, M.D., Presiding

The South as Testing Ground for the Regional Approach to Public Health and Public Welfare.—Howard W. Odum, LL.D., Director, Institute for Research in Social Science, University of North Carolina, Chapel Hill. Discussion.

Symposium on the Small Hospital

The Community Hospital.—Barry C. Smith, General Director, The Commonwealth Fund, New York.

Organization and Management of the Small Hospital.—Malcolm T. MacEachern, M.D., Associate Director, American College of Surgeons, Chicago.

Planning for a Small Hospital.—William Henry Walsh, M.D., Consultant Specialist on Hospitals, Chicago.

The Construction of the Small Hospital.—Carl A. Erikson of the firm of Schmidt, Garden and Erikson, Architects, Chicago. Discussion.

TUESDAY MORNING, 10:00

J. H. Musser, M.D., Presiding

The Program of the National Committee for Mental Hygiene.—Clarence M. Hincks, M.D., General Director, National Committee for Mental Hygiene, New York. Discussion.

Fundamentals of Industrial Hygiene.—T. Lyle Hazlett, M.D., Professor of Industrial Hygiene, University of Pittsburgh School of Medicine, and Medical Director, Westinghouse Electric and Manufacturing Company, Pittsburgh. Discussion.

The Relation of Anesthesiology to Medical Education.—Ralph M. Waters, M.D., Department of Anesthesia, University of Wisconsin Medical School, Madison. Discussion.

Tenure of Members of the Faculty in Schools of Medicine.—Anton J. Carlson, Ph.D., Frank P. Hixon Distinguished Service Professor of Physiology, University of Chicago. Discussion.

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TUESDAY, 12:30

What the Undergraduate College Should Give the Future Doctor.—William Mather Lewis, LL.D., President, Lafayette College, Easton, Pennsylvania.

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MONDAY, 6:30

Recent Impressions of British Medical Education.—Willard C. Rappleye, M.D., Dean, Columbia University College of Physicians and Surgeons, New York.

Presidential Address.—H. J. Lehnhoff, M.D., President, The Federation of State Medical Boards, Lincoln, Nebraska. Round table discussion.

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TUESDAY MORNING, 9:30

H. J. Lehnhoff, M.D., Presiding

Does Modern Medical Licensure Procedure Conform to the Accepted Standards of Medical Education?—A. C. Furstenberg, M.D., Dean, University of Michigan Medical School, Ann Arbor.

Examination Results Before Massachusetts State Board of Registration in Medicine.—Edward A. Knowlton, M.D., Holyoke; Stephen Rushmore, M.D., Boston.

American Graduates of British Medical Schools.—Harold Rypins, M.D., Secretary, New York State Board of Medical Examiners, Albany.

Citizenship and Medical Licensure.—J. Earl McIntyre, M.D., Secretary, Michigan State Board of Registration in Medicine, Lansing.

Legal Status of the Interne.—Fred E. Clow, M.D., Secretary, New Hampshire Board of Registration in Medicine, Wolfeboro. Discussion.

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TUESDAY AFTERNOON, 2:00

H. J. Lehnhoff, M.D., Presiding

Hospital Interne Service in the United States.—Robin C. Buerki, M.D., Director of Study, Commission on Graduate Medical Education, Chicago.

Looking at Health Insurance Abroad.—J. George Crownhart, Secretary, State Medical Society of Wisconsin, Madison.

Trends in the Distribution of Medical Care.—R. G. Leland, M.D., Director, Bureau of Medical Economics, American Medical Association, Chicago. Discussion. Executive session.

American Association for the Study of Goiter: Van Meter Prize Award.—The American Association for the Study of Goiter again offers the Van Meter Prize Award of Three Hundred Dollars and two honorable mentions for the best essays submitted concerning original work on problems related to the thyroid gland. The Award will be made at the annual meeting of the Association, which will be held in Cincinnati, Ohio, on May 22, 23, and 24, 1939, provided essays of sufficient merit are presented in competition.

The competing essays may cover either clinical or research investigations; should not exceed three thousand words in length; must be presented in English; and a typewritten, double-spaced copy sent to the Corresponding Secretary, Dr. W. Blair Mosser, 133 Biddle Street, Kane, Pennsylvania, not later than April 15, 1939. The committee, who will review the manuscripts, is composed of men well qualified to judge the merits of the competing essays.

A place will be reserved on the program of the annual meeting for presentation of the Prize Award Essay by the author if it is possible for him to attend. The essay will be published in the annual Proceedings of the Association. This will not prevent its further publication, however, in any journal selected by the author.

Report of Health Survey Forthcoming.—The California Medical Economic Survey, carried out in 1934 and 1935 at a cost of $100,000 and designed to give the facts regarding both private and public medicine and their relation to the economic picture in the state, is about to issue from the Graphic Arts Press in Washington, D. C. The survey was sponsored by the California Medical Association, the California State Board of Health and the Federal Public Health Agencies.

Much of the research in the survey was handled by Dr. Ernest F. Penrose, associate professor of economics in the University of California on the Berkeley campus, and Dr. Paul A. Dodd, assistant professor of economics on the Los Angeles campus. Doctor Dodd investigated medical care as an economic problem, and Doctor Penrose studied the public health and insurance phases of the survey. Particular attention was paid to the condition and the costs of both public and private medical care in the state and recommendations were made to cover defects the survey disclosed.

An abbreviated copy of the survey was published by the California Medical Association. According to Doctor Penrose the forthcoming volume is the first publication of the survey findings in full.—*Press Sheet, University of California.*

Traffic Officers Given Facts on Drinking Drivers.—Due to the looseness of existing traffic codes the drinking driver is given a valid, though somewhat left-handed argument when it comes to showing that a few libations do not impair his ability as a motorist. He can usually show that his driving is done more carefully, and with less danger of accident, than that of the epileptic, who might fall unconscious at the wheel, and others with unbalanced minds or unbalanced nerves, who are permitted to operate motor vehicles without the slightest restriction under the law.

This was stated to the first Pacific Coast Traffic Officers Training School at the University of California by Dr. George K. Rhodes, associate professor of clinical surgery in the University's medical school in San Francisco. Doctor Rhodes suggested that the best way for the public to upset that dangerous argument would be to devise a system whereby the prospective driver would be subjected to a medical examination and other tests.

Doctor Rhodes presented figures tending to show that 46 per cent of the traffic arrests are for drunken driving and that about 12 per cent of the average driving public are suffering from varying degrees of intoxication. Answering the question as to when a driver may be considered intoxicated, Doctor Rhodes said that a concentration of one-tenth of 1 per cent alcohol in the blood would begin to show indications of intoxication. A concentration of between 1-10 and 2-10 of 1 per cent would show actual intoxication, and from 2-10 to 3-10 of 1 per cent would show a dangerous degree of intoxication, particularly for the man himself, so dangerous in some instances that artificial respiration might be needed.

One out of every 250 drivers may figure to be intoxicated in some degree, Doctor Rhodes said. The peak age for drunken driving appears to be between 25 and 30.

Press Clippings.—Some news items from the daily press, on matters related to medical practice, follow:

Olson Names Board to Study Health Bills

Governor Olson yesterday named a state-wide committee of twenty-one members, headed by Chester H. Rowell, to make an exhaustive study of the compulsory health insurance bills pending before the Legislature.

The Governor has asked the committee to make a report to him on two companion measures, Assembly Bill No. 2172 by a group of authors, including Assemblyman Ben Rosenthal, Los Angeles, and on Senate Bill No. 1128 by Senators John F. Shelley, San Francisco, and Robert W. Kenny, Los Angeles.

Selected on Committee*

Those selected on the committee are: Paul C. Smith, general manager of the *Chronicle*; Dr. Samuel C. May of the University of California faculty; Sheriff Daniel C. Murphy, San Francisco; E. A. McMillan, San Francisco, representative of the Railway Brotherhoods; J. Vernon Burke, San Francisco, executive secretary of the Labor Non-Partisan League; Hugh Wilkins, Los Angeles, representing the Labor Non-Partisan League; Herman Stuyvelaar, secretary of the San Francisco District Industrial Union Council; Dr. Clyde Emery, Los Angeles; Dr. Paul Dodd, professor at the University of California at Los Angeles; Dr. S. J. Sperling, Los Angeles; Ansley Salz, San Francisco industrialist; Hazel C. Woods, representative of the California Nurses' Association; Dr. Thomas Addis, San Francisco; Professor Barbara W. Armstrong, of the law department of the University of California; Dr. Elmer Belt, Los Angeles; Dr. Philip King Brown, San Francisco; Dr. Francis Pottenger, Los Angeles; Dr. Eaton McKay, La Jolla; Dr. Aaron J. Rosanoff, State Director of Institutions; and Dr. G. Chester Gummess, San Francisco.

Medical Aid Plan

These bills set up a plan under which persons would be given medical services, hospitalization and laboratory and other services benefits. Drugs and medicines would be provided. The plan would include maternity cash benefits.

The program would be administered by a new bureau of medical services in the State Department of Employment.

A program of health insurance fund contributions by employers and employees is contemplated. Top contributions by employers would be 2 per cent of the pay roll covering low wage bracket workers. Top contributions by employees would be 1½ per cent in the case of salaries running in excess of $200 a month. Workers earning under $70 a month would be insured without making contributions.

Physicians would be permitted to register under the proposed setup for the purpose of contracting with the state to render services to beneficiaries.—San Francisco *Chronicle*, February 28.

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Doctor Pottenger Says Nation Will Adopt Health Insurance

Dr. Francis M. Pottenger, formerly president of the American College of Physicians and Surgeons, in an address before Town Hall at the Biltmore yesterday, said he approved of health insurance. His view is at variance with that of the State Medical Society.

"Compulsory health insurance," he said, "is the only plan which will insure complete, stable income from all groups that require medical care. No matter what may be done by medical men, some form of medical insurance which will give satisfactory service is sure to come."

He said that some form of health insurance like that in England is likely to come in this country eventually. He said that at present 50 per cent of the population of this country is being given medical care by the Government and that another 40 per cent lack funds to pay for a protracted illness.

Doctor Pottenger is head of the Pottenger Sanitarium at Monrovia.—Los Angeles *Times*, February 21.

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Use of Narcotics Drops in State

Sacramento, February 27 (AP).—Use of narcotics in California is rapidly decreasing, State Director of Institutions Aaron J. Rosanoff reported to Governor Olson's monthly council meeting today.

Doctor Rosanoff recommended the narcotic hospital at Spadra, which he said is the only state institution of its kind, be closed as a narcotic hospital and be converted to some other or more urgently needed use.

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* The list of twenty-one committee members appointed by Governor Olson include nine members of the medical profession, as follows: From San Francisco, Thomas Addis, M.D., and Philip King Brown, M.D.; from Los Angeles, Claude Emery, M.D., S. J. Sperling, M.D., Elmer Belt, M.D., Francis M. Pottenger, M.D., and Chester Gummess, M.D.; from San Diego, Eaton McKay, M.D.; from Sacramento, Aaron J. Rosanoff, M.D.

He said the hospital, with a capacity of 122 beds, now has but eighteen patients.

With the objective of reducing the population of the state hospitals, Rosanoff said, the department will coöperate with various health agencies in the administration of the malarial inoculation treatment for syphilis in cases with evidence of involvement of the nervous system. Such treatments will be given in all the state hospitals, he said.

The Council also heard Director of Public Works Frank W. Clark's prediction the Federal Government will coöperate in the construction of a steam-electric power plant at Antioch in connection with the Central Valley project.

The plant would cost approximately $20,000,000 and be designed to handle public power distribution prior to the completion of the Shasta Dam unit of the undertaking.

Clark asked Governor Olson to give immediate consideration to a request for $250,000 with which a preliminary study and survey of the Antioch project would be made.

Reporting on the work of the revised Golden Gate International Exposition Commission, Clark said a brief investigation had led him to the belief the state's chances of regaining its $5,000,000 investment "do not look too encouraging."

"Well, most fairs seem to end in deficits instead of surpluses," the Governor remarked.—San Francisco *Chronicle,* February 28.

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California Physicians' Service Incorporated*

Sacramento, February 3 (UP).—Voluntary insurance for medical service and hospital care was offered today by the California Physicians' Service in articles of incorporation on file with Secretary of State Frank C. Jordan.

The corporation is composed of members of the California Medical Association, but the voluntary medical service plan may be participated in by all doctors of medicine so desiring, the statement of incorporation said.

President Ray Lyman Wilbur of Stanford University and six prominent physicians signed the articles.

The statement of incorporation declared that "prompt and adequate medical attention and hospital care whenever needed" would be provided to the people of California on a budgeting basis "without injury to standards of medical service, without disruption of proper physician-patient relations and without profit to any agency."

All payments made by patients, the statement read, will be utilized for medical service and hospital care, except costs of administration. It assured efficient public and civic service "without commercial exploitation of patients or profession . . . and without restrictions of individual right freely to select the doctor and hospital desired."

Increased costs of medical attention were attributed to the "very advances made by modern science." The statement predicted medical service and hospital costs would increase as new methods and equipment are discovered.

San Francisco was designated as headquarters of the new corporation, which has administrative membership of seventy-five physicians and an unlimited professional classification and beneficiary group. — San Francisco *News,* February 3.

* * *

California Medical Body Acts to Form Health Group

Periodic Payments Would Care for Members in Ill Health

Sacramento, February 3 (INS).—Because the "always unpredictable injury or illness is a financial catastrophe too great to be borne by some persons," and because "the total cost of these injuries and illnesses is within the means of a group," articles of incorporation had been filed in Sacramento today by all members of the California Medical Association for the "California Physicians' Service."

"Open to All"

Under terms of the articles, the group would "establish and maintain a fund by periodic payments by its beneficiary members for medical services."

There is no limit to the authorized number of beneficiary members.

The articles set forth that any member of the service may select the doctor, hospital and treatment desired.

The fund for this group treatment would be accumulated by payment of dues but members would not be liable to assessments.

The Members

Directors of the socialized medical group are:

Dr. Ray Lyman Wilbur, Stanford University; C. Kelly Canelo, San Jose; W. Earl Mitchell, Berkeley; Samuel Ayres, Jr., Los Angeles; Alson R. Kilgore, San Francisco; Lowell S. Goin, Los Angeles, and T. Henshaw Kelly, San Francisco.—San Francisco *Call-Bulletin,* February 3.

Name Two Hospital Supervision Groups

Los Angeles County General Hospital supervision was put under scrutiny by the Board of Supervisors today with appointment of two committees, one to effectuate medical school supervision of all hospital work, the other to study reforms in the method of collecting hospital bills from those less able to pay.

The committees were announced by Supervisor Gordon L. McDonough, Chairman of the Hospital Advisory Committee.

To put into effect the recently voted plan for having medical supervisors from the two medical schools, University of Southern California and College of Medical Evangelists, supervise the 479 physicians and surgeons who give part of their time to General Hospital, the following committee was named: Dean Paul S. McKibbon, of the U.S.C. medical school; Dean Percy M. Magan, of the College of Medical Evangelists; Dr. Walter A. Bayley, member of the attending staff; County Manager Wayne R. Allen and County Counsel John H. O'Connor.

To study the hospital billing system, recently complained of by the Grand Jury in a report which said that "indiscriminate billing of indigents resulted in unjustifiable hardship and hounding of persons unable to pay," the following committee was selected:

County Auditor Joseph M. Lowery, Superintendent of Charities; Rex Thomson and Grand Jury Auditor Eugene Berger.—Los Angeles *Examiner,* February 5.

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Indigents Face Ambulance Toll

Recommendation that indigents who used county ambulance service prior to July 1, 1937, be required to pay $2.50 was made yesterday to the Board of Supervisors by J. H. O'Connor, county counsel.

O'Connor pointed out that previously the board had ruled that after June 29, 1937, indigents would be required to pay this amount for ambulance service, but no provision previous to this time had been made.

An order to effect collection of this money will be passed on by the board at tomorrow's meeting.—Los Angeles *Examiner,* February 6.

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Rule Given on Medical Aid

A ruling of Attorney General Earl Warren yesterday limited the right of private institutions or unlicensed persons to render medical services through the medium of a hired physician and surgeon.

In a letter to Charles B. Pinkham, Secretary-Treasurer of the Board of Medical Examiners, the Attorney General held that a licensed physician cannot render medical services to patients of unlicensed persons in consideration of a salary paid to him for performing such services.

In addition, the ruling held that a private institution cannot represent itself as rendering medical services and hire physicians to render such services.

Pinkham's request for the ruling cited the case in the first instance of two unlicensed persons operating a sanatorium and employing a licensed medical man as medical director.—San Francisco *Examiner,* February 11.

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Wider Use for Hospitals of Counties, Plan

More general use of the facilities of county hospitals will be possible if a bill now before the Legislature, sponsored jointly by doctors and farmers, becomes a law, according to Dr. Louis A. Packard, Bakersfield, Chairman of the Committee on County Hospitals and a member of the Council of the California Medical Association.

Speaking before Santa Maria Valley Farm Center last night, he told members that the farmers and doctors, former enemies on the county hospital situation, had finally got together on a bill which they are jointly sponsoring (Assembly Bill 2499) and asked careful consideration of the measure and support for it.

Doctor Packard said the measure agreed upon between representatives of the Farm Bureau Federation of the State and the California Medical Association, would eliminate the words "dependent" and "indigent" from the present requirement for admission to county hospitals and set up three classes of patients—(a) those unable to pay; (b) those able to pay something, and (c) those able to pay actual costs, and provide for their treatment in county hospitals, those being able to pay being allowed to call in doctors of their choice.

He declared that the present county hospital regulations "are chaotic" and are mostly the result of court decisions and interpretations by the attorney general and that the pending bill will clarify present obscurities.

He said a wider use of public hospitals is advisable since 40 per cent of the people of the United States, according to federal statistics, are living on an income of $600 a year or less.—Santa Maria *Daily Times,* February 7.

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* For Articles of Incorporation, see CALIFORNIA AND WESTERN MEDICINE, February, 1939, on page 134.

Smallpox Increase Reported in State

San Francisco, February 4 (AP).—Dr. W. M. Dickie, State Director of Public Health, today warned that smallpox is on the increase in California and that all persons who have been exposed should be vaccinated immediately regardless of how recently they may have been immunized.

He said seventy-seven cases of smallpox were reported last month from seven counties as compared with twenty-eight cases in December from four counties.

Smallpox now prevalent, he said, is a mild form of the disease and in early stages may be mistaken for influenza.—Los Angeles *Examiner*, February 5.

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Battle Rages on Municipal Health Service Plan of San Francisco

Charging unfair discrimination, spokesmen for osteopaths and chiropractors ended a spirited session with the City Health Service Board last night, announcing their intention to ask the courts to force their inclusion in the health plan for which city employees assess themselves each month.

The pronouncement was made by Dr. W. W. Vanderburgh on behalf of the osteopaths and by Dr. David T. Jones and Attorney Newell Hooey, speaking for the Affiliated Chiropractors of California.

Their determination was voiced after they declared they would not be discriminated against, and Cameron King, board chairman, had asserted he would not be insulted by them or "anyone else."

The drugless practitioners attended the board meeting for the purpose, they said, of getting a "final ruling," promised two weeks ago, on whether or not they were to share in the health plan.

Fight Starts Quickly

Chairman King had hardly launched the hearing with the declaration that the "plan of inclusion" was, in reality, not a plan of inclusion, but a demand for a separate plan calling for an additional $2.50 per month payment by city employees or dependents, before a quarrel broke.

Attorney Hooey challenged that interpretation and accused the board of misleading city employees by a letter sent to them declaring the plans submitted by osteopaths, chiropractors and drugless practitioners "seem to call for separate contributions of $2.50 per month by members seeking such service."

A sharp exchange brought Doctor Jones to his feet with the question: "Is it the medical doctors who won't work with us or is it the extra $2.50 that's at the bottom of this? Let's get it straight."

A "Damned Shame"

"I'm not going to sit here and be insulted by you, Davey Jones, or Mr. Hooey, or anyone else," Chairman King answered.

After further conversation, Doctor Jones returned to the attack and asked if it wasn't true that the crux of the "discrimination" was that doctors of medicine didn't want to include others. King replied that was "not all, but part" of the situation. Declaring "it's a damned shame that such things can exist within a democratic government," Doctor Jones said, "we are going ahead with court action."

His assertion was echoed by Doctor Vanderburgh, who declared osteopaths have been recognized on a parity with physicians and surgeons by State and Nation and "we're not going to lay down here."—San Francisco *Chronicle*, February 16.

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Medical Art Association

The San Francisco branch of the American Physicians' Art Association will open its first local show Monday. And for the first time in its seventy-two years the San Francisco County Medical Society is sponsoring an art show in its quarters at 2180 Washington Street. Cosponsor is the American Medical Association.

The national group was organized last year by Dr. Francis H. Redewill, its present president and secretary. Its first exhibition was held at the San Francisco Museum of Art during the medical convention here. More than 600 entries were shown at that time.

Physicians who are showing in the art exhibition are:

R. W. Burlingame, R. De R. Barondes, Martha Mottram, Ernest Nast, J. M. B. Olmsted, Colonel Brooks Grant, Paul Wedgewood, Harrington B. Graham, Asa Collins, Portia Hume, J. Tavlopoulos, Emelie Anderson De Eds, L. Courtright, Rodoric O'Connor, Signor Ettore Cadorin, Otto Schulte, W. W. Henry, W. H. Strietmann, Avard Fairbanks, W. K. Fisher, Mrs. Dr. Fred Stauffer, Fred Stauffer, F. H. Redewill, Ralph Sweet, Julius Goldsand.—San Francisco *News*, February 11.

New San Fernando Unit to Receive 109 Patients

San Fernando, January 31.—Containing modern accommodations and treatment facilities, the new $197,000 addition to the United States Veterans' Hospital will be opened to 109 patients tomorrow under direction of Col. D. C. Farnsworth, M. D., chief of staff.

Plans have been made for the transfer of eighty patients from Sawtelle, while the remaining twenty-nine will be selected from waiting lists. The hospital now will have 359 patients under treatment.

Doctors' and nurses' quarters are provided in the building, as well as kitchens and dietitians' rooms.

Automatic tray servers, operated similarly to elevators, are an innovation in the building. Doctor Farnsworth pointed out that twenty-four trays can be sent quickly to the patients without loss of time or inconvenience to nurses.

There is a shower room for use by wheel-chair patients.

Attending the patients are fourteen doctors, a dentist, forty-three nurses and the executive staff, who will be present when dedication ceremonies are conducted February 14 under direction of the American Legion.—Los Angeles *Times*, February 1.

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Hospital Plan Draws Patrons

Million and Half Join With Service Groups in Year

Chicago, January 29 (AP).—Nearly a million and a half new subscribers enrolled in the fifty-three nonprofit hospital service plans during 1938, Dr. C. Rufus Rorem of the American Hospital Association, said today.

Total subscribers neared the 3,000,000 mark on January 1, 1939, he said, compared with almost 1,400,000 the first of 1938.

The plan was started in sixteen additional places during the last year. They are Atlanta, Los Angeles, Decatur and Alton, Illinois; Newark, Canton, Toledo and Youngstown, Ohio; Harrisburg, Pittsburgh and Philadelphia, Pennsylvania; Denver, Louisville and Covington, Kentucky; Danbury, Connecticut, and a state-wide plan in Mississippi.

The nonprofit plans approved by the American Hospital Association are a form of nongovernmental social insurance by which the hospitals guarantee services to subscribers.—Los Angeles *Times*, January 30.

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Municipalities Studying Indigent Hospitalization

Chicago, February 12 (Exclusive).—With many local governments dependent upon nongovernmental hospitals to care for their needy sick because of the insufficiency of public facilities, the American Public Welfare Association and the American Hospital Association today suggested that cities adopt systems of paying for the care of indigents in private hospitals at a flat rate per day.

Findings of Survey

The report, made jointly by the two associations, showed that about 1,300 of the 3,000 counties in the United States have no governmental hospital. In the 296 most populous counties nongovernment hospital beds constitute approximately two-thirds of the total accommodations.

Two Pay Systems

Although many cities are paying for hospital care of their indigents according to services rendered, some of them are paying on a lump sum or subsidy basis. It was suggested that payment be made exclusively on the basis of service actually rendered, at a flat, per diem rate, including all charges for laboratory work, x-ray and other services. A single rate cannot be predetermined for all places, it was pointed out, but must be established individually in accordance with local conditions.—Los Angeles *Times*, February 13.

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California Cash Dole Load Reaches Total of 307,303

California has reached a new peak in cash dole relief to unemployed persons with 307,303 names carried on the State lists, according to Dr. H. Dewey Anderson, State Relief Administrator.

This figure was taken from the State files for the week ending February 2, Doctor Anderson said.

Tells Increase

The total case load has increased 5 per cent during the last week and 25 per cent since last January 1, according to the administrator.

The increased unemployment problem in California exists despite the fact that WPA employment has been increased 22 per cent, according to the official statistics. Of those receiving SRA relief, 107,000 are living in Los Angeles County and the number is increasing daily, Doctor Anderson pointed out, indicating a heavy winter influx of transients from other states.

More Funds Needed

"If California is to provide even the bare necessities of life for these persons," Doctor Anderson said, "it will be necessary to reduce the present dole of $36 a month for a family of four or $16 for a single person, or for the State Legislature to appropriate approximately $6,000,000 to defray the cost of this charity until June 30."—Los Angeles *Times*, February 13.

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$23,757,218 Paid in Job Insurance

Unemployment compensation checks to the amount of $23,757,218.36, about $2,159,747 monthly, were paid to 295,211 jobless men and women in the State during eleven months of last year, the State Department of Employment announces in a report just released.

California's average weekly payment for total unemployment benefits aggregated $10.53, which sum was identical to the average national weekly payment, the report states.

Pointing out that benefits for total unemployment first became payable in the State on February 7 of last year, the report declares that 2,484,311 checks were distributed from that date to December 31.

Summarizing its finances for the year, the department reports that the trust fund, including net collections and earned interest, totaled $130,748,678.21, and after deducting the amount paid out the fund had a reserve balance on December 31 of $107,033,324.84.—Los Angeles *Examiner*, February 13.

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10 Million in Jobless Checks Issued County

The State Department of Employment in Sacramento announced today that 1,092,043 unemployment compensation checks were issued in Los Angeles County during 1938, having a total value of $10,692,538.76.

Carl L. Hyde, executive director of the department, issued a report which stated that 470,025 people throughout the State applied for benefits, with 383,736 of these found to have valid compensation claims. He said that 2,484,311 benefit checks, aggregating $23,575,218.36, were issued throughout the State last year.

The number of checks issued and their value to cities in Los Angeles County is as follows:

Los Angeles County, 1,092,043 checks, $10,692,538.76; City of Los Angeles, 457,400, $4,323,497.16; Covina, 5,264, $44,856.85; Culver City, 25,565, $257,674.72; Glendale, 64,242, $649,189.52; Hollywood, 96,023, $980,658.26; Huntington Park, 129,433, $1,320,315.11; Inglewood, 46,397, $482,358.20; Long Beach, 66,191, $666,907.04; Pasadena 29,956, $296,632.83; San Pedro, 32,159, $262,892.77; Santa Monica, 22,614, $230,004.26. —Los Angeles *Herald-Express*, January 30.

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Social Eugenics*

I have just been reading in *The Times* the semiannual report of Rex Thomson, superintendent of public charities, to the Board of Supervisors. He reports that there are about 100,000 persons in the city and county of Los Angeles on the dole, receiving public relief.

Then I recalled a similar report on the city of Rome and its immediate environs in the last years of the republic. The total population of Greater Rome was estimated at 3,000,000, about the population of Los Angeles city and county, and the number of what the report termed the rabble, living on "food and the circus," was given at 100,000.

The army and the rabble dictated who should be the dictator. For more than 200 years the changing governments sent the legions to despoil and levy tribute on the whole of the Mediterranean Basin, carrying the treasure to Rome to support the populace. Whenever there was a shortage in the dole riots followed; the ruling dictator was devitalized and one who promised the most in the way of the dole was clad in the royal purple, which, almost without exception, proved to be a garment of Nessus, fatal to Hercules.

But the time came, as it had to come, when the "barbarians" and the despoiled peoples revolted and despoiled Rome.

Naturally, I am wondering how long the city and county of Los Angeles can carry a similar load. We have no foreign regions to despoil; we can only despoil those who are producing among ourselves. What will happen when the last despoiled taxpayer goes on the dole?

I find in another report that some 50,000 other persons applied here for relief, but thousands of petitions from those qualified to receive relief were rejected because additional funds were not available.

It seems to be a case of the devil take the hindmost.

The sociologist is working on the economic problems involved. But the eugenist is primarily interested in the human material of these 150,000 actual or would-be dependents.

Not all the needy are physical or mental defectives; but about three-fourths of the physical and mental defectives are on the dole. It has been iterated and reiterated that poverty and disease are no crimes; but the hereditary physical and mental weaklings on the dole are, to a large measure, the victims of crimes of omission committed by organized society during the past three or four generations. So long as these defectives are permitted to reproduce their kind, the number on the dole, a burden to themselves and the community, will continue progressively to increase. The actual number on the dole is double that five years ago.

For at least three generations philanthropists and sociologists have been thinking wishes, hoping that some higher power would intervene to eliminate the hereditary taint in the bloodstream of the next generation. Despite their wishes, hopes and prayers, the progressive taint persists, with a multiplying ratio in each succeeding generation. Is this not proof enough that the powers that rule the universe, use what name you will, cast on the human animal the full responsibility for protecting its bloodstream?

When these human animals reside in populous communities and organize governments, their first duty would logically be to act collectively to keep that bloodstream pure. What are we of California, what are we this side of the Atlantic, doing about it? We destroy lesser breeds that carry germs which infect the human blood; but the human disease carriers we preserve at public expense. What folly!—Los Angeles *Times*, February 12.

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United States Aid Asked to Help Migrants

Washington, February 15 (AP).—Federal aid in solving problems arising from the migration of hordes of destitute families to California was demanded of President Roosevelt today by that State's congressional delegation.

A petition left at the White House by Representative Elliott (Democrat, California), asserted immediate action was imperative and suggested a broad program for State and Federal coöperation.

"California feels," the delegation informed the President, "that interstate migration is a national, not a local problem, and that in general the cost of necessary care for people who at present have no legal residence in any state should be borne by the Federal Government."

Describing the situation in California as "critical and almost desperate," the petition said "thousands of penniless newcomers" have given rise to serious employment, health, relief, housing, and education problems, and added:

"Generally, our position is: First, that our California standards of old age pensions, of relief, of education, of wages, should not be sacrificed to our efforts to do our part to solve this great national problem, and second, that in spite of the excellent work done by farm security and other Federal agencies, the Federal Government has so far not contributed its share to its solution."—San Francisco *Chronicle*, February 16.

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California Migrant Problem

President Roosevelt has ordered formation of a special group to solve the critical relief problem arising in California from the influx of thousands of economically distressed families, it was disclosed yesterday.

The President's action was announced by Representative Elliott, California Democrat, according to Associated Press dispatches from Washington, D. C. WPA Administrator F. C. Harrington will head the new group.

Elliott made public a letter from Stephen Early, White House secretary, in which the latter described the President as "strongly sympathetic with California."

Chairman Named

Early said the President left instructions before departing Thursday night for Florida to have Harrington serve as chairman of the special group. Early added:

"The President hopes that through Colonel Harrington's coördination, the various departments and agencies of the Federal Government will find a way without delay to extend all possible coöperation to the State in alleviating the conditions existing."

Key Members

The President suggested that key members of Administrator Harrington's group should include the heads of the Farm Security Administration, the United States Employment Service, the Housing Authority, and the Surgeon General's Department.—San Francisco *Examiner*, February 19.

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Migrant Aid Plan Mapped

Californians in House to Ask Presidential Support for Program

Washington, February 13 (AP).—California House members seeking a cure for a serious migrant relief problem today agreed on a multiphased program of Federal coöperation and arranged to ask President Roosevelt for his support.

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* By Fred Hogue.

Elliott's Report

Representative Elliott, chairman of a group studying the problem, said a subcommittee of three hopes to present the plan to the Chief Executive before he leaves for his Caribbean cruise. He said he and Representatives Voorhis (Democrat), and Welch (Republican), the other subcommittee members, will ask for a Wednesday appointment.

Details of the program were not made public. It is understood, however, to contemplate a concerted attack on all phases of the transient problems, including employment, health, relief, housing and education.

Program's Scope

Members would not be quoted, but these were reported to be the principal steps which would be suggested to the President:

Expansion of the Farm Placement Service so that migratory agricultural workers can be given accurate information concerning employment opportunities or their lack in other parts of the nation.

Additional Federal funds to aid the agricultural workers —health and medical assistance in improving health conditions among the State's surplus population, and to encourage establishment of clinics in Federal migratory camps.

Food Provision

Development of a program whereby the Surplus Commodities Corporation would furnish a balanced ration of foodstuffs to undernourished transients.

Inauguration of a system of grants to states to defray cost of relief extended to nonresidents by the states or counties.

Establishment of more Federal camps for migratory agricultural workers and the development also of a very low-cost housing program designed to take transients out of shack towns.

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State Assured of Aid for Migrants

Washington, February 23 (AP).—Representatives of Federal agencies were reported today to have agreed California's critical migrant relief problem had nation-wide implications and its solution should be attempted on such a basis.

Californians who attended the first meeting of the group, formed at the suggestion of President Roosevelt, predicted legislative recommendations would be forthcoming to deal with the situation.

They said a committee would be organized immediately to formulate a program.

"Colonel F. C. Harrington (WPA administrator) and the others agreed with us today," said Representative Leland M. Ford (Republican, California), "that the problem looked national in scope, and it probably would have to be solved by specific legislation."

Meanwhile, Harrington agreed, said Ford, that Federal agencies should give widest possible dissemination to information that unemployed persons "should not come to California from other states seeking jobs."

R. W. Moore, secretary to Representative Elliott (Democrat, California), said Harrington named William R. Lawson, Northern California WPA head, as chairman of the interdepartmental committee, and told the group "to devote its whole time to finding a solution."

California House members had appealed to the President to help solve the transient problem.—San Francisco *Chronicle*, February 24.

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State May Get Migrant Aid

President Orders WPA to Call Problem Conference

(By a *Times* Staff Correspondent)

Washington, February 18 (Exclusive).—Federal officials were summoned today, in response to orders from President Roosevelt, to work out a plan through which the Federal Government can assist California in taking care of the transient relief load.

Under the direction of Works Progress Administrator Harrington, six government agencies will meet next week and study a request from the California delegation in Congress for Federal coöperation in stopping the westward migration of job-seekers and farmers from the dust bowl, and in lightening the present burden on State and local bodies. Harrington requested five other officials to meet with him Thursday to discuss the problem.

Notice of Survey

The movement was launched in response to instructions issued by the President before departing for his vacation trip to the Caribbean. Mr. Roosevelt was stirred to action by a lengthy appeal submitted by a committee headed by Representative Elliott (Democrat), of Tulare, which said that the influx of needy persons from other states is undermining California's standards of living, presenting serious social and health problems, and threatening the State's financial resources.

Notice that the President has asked WPA to survey the situation was received by Representative Elliott today. A letter from White House Secretary Stephen T. Early said "the President is in strong sympathy with California because of the migration there of large numbers of 'economically distressed' from other sections of the country."

Committee to Form

Early added that Mr. Roosevelt hopes the various Federal departments can find some method of alleviating the conditions which are causing concern to municipal, county, and State authorities.

The President directed Harrington to form a committee which will "undertake to extend to California all possible coöperation with a view to finding a solution to the problem" outlined by the congressional delegation. Secretary Early wrote the WPA head that Mr. Roosevelt "thought you should call upon" Farm Security Administrator Alexander, Surgeon General Parran, the United States Housing Authority and the United States Employment Service to aid in working out a relief plan.—Los Angeles *Times*, February 19.

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Nonmedical Service City Health Issue

Municipal Employees Polled to Determine If Additional Charge Should Be Assessed

A poll of members to determine whether an extra charge should be made for service by drugless practitioners was started yesterday by the municipal employees health service board.

Meanwhile, complaints of participating doctors concerning financial policies of the service were under investigation by the County Medical Society. The protests were based on delayed payments of fees and alleged slicing of bills.

Problem Outlined

Regarding possible service by osteopaths, chiropractors, and drugless practitioners, the board declared:

"The question of cost is at the heart of the difficulties. Plans for osteopathic, chiropractic, and drugless practice service submitted by representatives of those three professions seem to call for separate contributions of $2.50 per month by member seeking such service.

Hospital Ruling

"On the other hand we are informed that none of the hospitals under contract with the health service board admit osteopaths or chiropractors to practice in them.

"The sum of $2.50 would be excessive where no service can be rendered in a hospital case."

The ballot sent members asked them if they required service of drugless practitioners and whether they would be willing to pay an additional fee. The average fee under the present system is $2.50 per month.—San Francisco *Examiner*, February 15.

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Insurance for Medical Service Offered by Doctors

Wilbur and Six Prominent Physicians Sign Incorporation

Sacramento, February 4 (UP).—Voluntary insurance for medical service and hospital care was offered yesterday by the California Physicians' Service in articles of incorporation on file with Secretary of State Frank C. Jordan.

The corporation is composed of members of the California Medical Association, but the voluntary medical service plan may be participated in by all doctors of medicine so desiring, the statement of incorporation said.

President Ray Lyman Wilbur of Stanford University and six prominent physicians signed the articles as directors.

The statement of incorporation declared that "prompt and adequate medical attention and hospital care whenever needed" would be provided to the people of California on a budgeting basis "without injury to standards of medical service, without disruption of proper physician-patient relations and without profit to any agency."

All payments made by patients, the statement read, will be utilized for medical service and hospital care, except that costs of administration would be deducted. It assured efficient public and civic service "without commercial exploitation of patients or profession . . . and without restrictions of individual right freely to select the doctor and hospital desired."

Increased costs of medical attention were attributed to the "very advances made by modern science." The statement predicted medical service and hospital costs would increase as new methods and equipment are discovered.

"The cost of always unpredictable injury or illness is a financial catastrophe too great to be borne by the few citizens of California . . . although the total cost over any period is within the means of a group," the statement declared.

San Francisco was designated as headquarters of the new corporation, which has an administrative membership of seventy-five physicians and an unlimited professional classification and beneficiary group.

Directors signing the petition for incorporation were Ray Lyman Wilbur, C. Kelly Canelo of San Jose, W. Earl Mitchell of Berkeley, Samuel Ayres, Jr., of Los Angeles, Alson R. Kilgore of San Francisco, Lowell S. Goin of Los Angeles, and T. Henshaw Kelly of San Francisco.—Visalia *Morning Delta*, February 4.

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Federal and State Bill Submitted at Washington

Washington, February 28 (AP).—Legislation to carry out Administration aims for a greatly expanded public health program was introduced today by Senator Wagner (Democrat, New York), author of much social legislation.

His "national health bill" called for a Federal outlay of $80,000,000 the first year, increasing to more than $250,000,000 annually within three years.

Wagner said the Federal funds would go to states as grants for expanding general public health work, child and maternity care, construction of hospitals, medical care, and temporary and permanent wage payments for workers disabled by sickness and disease.

Immediately there were some signs of criticism because of the cost involved.

Senator Vandenberg (Republican, Michigan) announced he was opposed to "any expansion of the Government's social services until we begin to pay for those we've got."

"We can't go on spending $15,000 every minute, while taking in only $8,000, and survive," he added.

Another Republican, Senator White of Maine, commented all members of Congress thought it was "time we go pretty slow" on additional spending.

In Chicago, Dr. Morris Fishbein, Editor of the American Medical Association, advocated "careful consideration" of the bill by Congress.—San Francisco *Chronicle*, March 1.

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Migrant Aid Appeal Made*

Californians Ask President to Assist Needy Horde in State

Washington, February 15.—A system of Federal grants-in-aid to California, and other Government assistance toward feeding, clothing, and giving employment to approximately 200,000 penniless transients who have entered the State during the last three years was asked of President Roosevelt today by the California House delegation.

Calling attention to conditions which were termed "nothing short of deplorable," the House group—headed by Representative Elliot (D.), Santa Maria—requested Federal funds for the relief of migratory workers who flooded California when serious drought conditions forced them from their own states.

Expected to Remain

From 150,000 to 250,000 "floating families" can be expected to remain in California permanently, the delegation declared, adding that "we know that in spite of anything that can be done, more people will come in the future."

Among the suggestions projected by the delegation's Committee on Interstate Migration were (1) expansion of the farm placement service to help migratory agricultural workers find employment; (2) working out of a program through which the Surplus Commodities Corporation would furnish foodstuffs to the State Relief Administration or to the Farm Security Administration for distribution to the transient needy; (3) a system of Federal grants to defray the cost of relief, with the Social Security Board the probable administrator; and (4) establishment of more camps of the type now operated by the Farm Security Administration.

Lack of Jobs Told

Other Federal agencies which would be called upon for assistance include the United States Housing Authority, the Works Progress Administration, and the Public Health Service.

Approximately three workers exist for every available job in California, the committee told the President, and taxpayers of the State are carrying an almost unbearable burden in order that wandering families from other sections of the country may be cared for.

The Editorial Circuit Rider*

A Symposium of Editorial Comment from California Newspapers

Need for the proposed health insurance program in this State is generally recognized, according to many California editors.

If the medical profession itself can work out a practical plan, it was agreed, both the patients and the doctors would benefit.

"There is a definite need," notes the Calexico *Chronicle*, "for some system where medical care can be secured at less expense for classes that frequently neglect calling a doctor for an illness or accident because the expense would be prohibitive or at least restraining. This need is recognized by the California Medical Association. Apparently it is considered compatible with the best interests of doctors to attempt to evolve some sort of insurance system whereby that need be met."

"That the medical profession itself has taken the initiative in attacking the problem is the best assurance of the plan's successful operation," said the Monterey Peninsula *Herald*. "Freedom from political interference and probable bureaucratic evils of socialized medicine, at least during the experimental stages, will mean much in the way of efficiency and economy, with resulting benefits to both the profession and the public. That threat of socialized medicine has hastened the decision of the profession to enter this field may be admitted without detracting from the credit due the profession for its decision, the California leadership in the realm of progressive action looking toward a healthier, happier citizenry is more firmly established as a result."

"The plan," states the San Jose *News*, "seems to get away from most of the dangers which have caused the medical men in general and some laymen to look askance at such proposals. The patient may select his own physician and his own hospital and the personal element of trust and confidence between patient and physician which is so important in the treatment of illness will be retained."

"Although the plan has been highly controversial, meeting opposition within the medical profession," declares the Stockton *Record*, "it does offer advantages to the doctors. They know they will get some remuneration for their services rather than having uncollectible fees on their books. Programs such as that adopted in California—and to be followed in other states—were inevitable to meet changing conditions and to preclude governmental entry in the socialized medicine field."

"The plan's intent," comments the Alameda *Times-Star*, "is proper, but how it would work out and whether or not it would actually result in the lowering of the standards of the profession is a matter to be taken into account. . . . Socialized medicine may come but it must not be adopted merely on the theory, the actual working of it being the only real criterion by which it may be judged."

"How the plan would work," concludes the Eureka Humboldt *Standard*, "is something upon which nobody can hazard a guess, since there is no precedent upon which to base a prediction. But doubtless it will appeal to a vast number of people. In any event, the State's medical profession certainly has evidenced sincerity of purpose in the performance of its basic job—to keep the public well."—Yreka *News*, January 30.

* * *

President Roosevelt Orders Study of Migrant Problem

Washington, February 18 (AP).—President Roosevelt, it was disclosed today, has ordered formation of a special group, headed by F. C. Harrington, WPA administrator, to attempt solution of a critical relief problem in California arising from the migration there of thousands of economically distressed families.

The President's action was announced by Representative Elliott (D., Calif.), who made public a letter from Stephen Early, White House secretary, in which the latter described the President as "strongly sympathetic with California."

Early said the President left instructions before departing Thursday night for Florida to have Harrington serve as chairman of the special group, and added:

"He hopes, through Colonel Harrington's coördination, that the various departments and agencies of the Federal Government will find a way without delay to extend all possible coöperation to the State in alleviating the conditions existing.

Early said the Chief Executive had suggested that the heads of the Farm Security Administration, the United

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* By Lorania K. Francis, *Times* Staff Correspondent.

* By J. F. McLaughlin, United Press Staff Correspondent.

States Employment Service, and the Housing Authority, as well as the Surgeon-General should be made key members of Harrington's group. He also authorized the WPA administrator to "call in such others to make this group representative of Federal departments and agencies whose works are related to various phases of California's problems as a whole," Early said.

Presidential action followed quickly the receipt of a petition from California House members urging immediate steps be taken to help the State solve its transient relief problem.

Members told the President that thousands of penniless families fleeing drought and depression, had crossed into the State in recent years and had created unprecedented relief, employment, health, housing, and education problems.—Oakland *Tribune*, February 18.

* * *

Health Plan Growth Seen

Group Says Medical Insurance May Care for Forty Million

Cleveland, February 8 (AP).—An American Hospital Association accountant predicted today 40,000,000 Americans will have guaranteed hospital and medical care by 1944 if doctors agree to supplement the group hospital insurance plans now in effect in fifty-two cities.

The accountant was Dr. C. Rufus Rorem of Chicago, Director of the Committee on Hospital Service of the American Hospital Association.

Approximately 3,000,000 persons were participating in the group hospital insurance plans last January 1, Doctor Rorem said. This figure, he predicts, will increase to 12,000,000 by 1942 under the force of guaranteed hospital service alone, and would swell to 40,000,000 by 1944 if doctors agree to supply medical service under similar arrangements.

Plan Explained

Under the hospital service plan, subscribers pay certain amounts of money every month; some of these subscribers go to their local participating hospitals for care; the plan then pays the hospitals for the care given, retaining a reserve for epidemics and administration costs.

Heads of the various community plans came here today for a midwinter conference. Their officials expressed hope physicians and surgeons soon will embrace the hospital plan and provide medical care under a similar arrangement.

Frank Van Dyk, Director of the Associated Hospitals of New York, said Government medical regulation is inevitable unless some such plan of group medical care is made nation-wide by the medical profession itself.

Doctors Warned

"This program is growing so fast doctors will be forced into it whether they like it or not," he said. "If they 'strike,' the only alternative is Government control."

He said studies have shown such combined medical-hospital care could be provided in New York for not more than $3 a month a family or $15 a year for an individual.—Los Angeles *Times*, February 9.

* * *

Thomson Denies Department Costs Tenth of Aid Funds

Rex Thomson, Superintendent of County Charities, yesterday denied the administrative costs of his department are more than 10 per cent of relief money expended, the highest of any county in the State.

Thomson said this in a letter addressed to Wayne Allen, chief administrative officer, following release of a report on relief costs for all the counties in California.

Orange Second

Allen's report showed Los Angeles County uses more money than ten counties. Orange County was second with 8.91 per cent for administration, while Sacramento was lowest with 2.98 per cent.

"A few years ago nearly 20 per cent of charity money went for administration." Thomson said. "This proportion has been reduced each succeeding year. In 1937-1938 it was 10 per cent, and now it is less than 8.5 per cent.

Promises Further Cut

"This will be further reduced in the budget request for 1939-1940, which will be submitted to your board for consideration shortly," the superintendent's letter said.

Thomson recently explained that a comparative report of the costs expended by counties in the State is impossible because of widely divergent methods of accounting.

"Considerable effort is being made by Federal organizations to establish uniform systems of determining expenditures on a comparative basis for all counties," he said.

"This county has a higher case load per capita of relief clients than forty-eight of the State's fifty-eight counties. It is possible to make more reductions in administrative costs. Such reductions, however, would jeopardize the ability to prevent distribution of relief money to ineligible persons."

The superintendent said this county gives relief services not found elsewhere in the State. He stated expenditures had been charged against the collection department, but no allowance apparently made for nearly a million dollars collected annually from persons who regained ability to pay.—Los Angeles *Times*, February 21.

* * *

Migrant Labor Influx to Southland Slackens

San Francisco, February 15 (AP).—A decrease in migratory workers in Southern California was reported today by Dr. S. F. Farnsworth, coördinating officer of the State Department of Health.

Doctor Farnsworth returned today from a survey of southern counties, where agricultural work is in progress. He said fewer migrants were entering the State in search of agricultural work, and that sanitary and living conditions among farm workers has shown considerable improvement.

No Squatter Camps

In Imperial County, usually the location of the major problem this time of year, there are no squatter camps and no ditch-bank camps, he said.

Doctor Farnsworth reported that more than 700 persons are residing at the Federal Farm Security camp at Brawley, and more than 1000 are at the temporary camp at Calipatria.—Los Angeles *Times*, February 16.

* * *

Hospital Plan Advice Asked

Supervisors Refer Proposed Changes to Two Committees

The proposed change in the administration of General Hospital yesterday was referred to the Lay Advisory and Medical Advisory committees of the institution by the Board of Supervisors.

On a resolution presented recently by Supervisor William A. Smith, the change would involve the ouster of Everett Gray, executive superintendent of the hospital, merging his post with that of Rex Thomson, Superintendent of Charities.

A plea by the Lay Advisory Committee that it be permitted to offer its recommendation on the proposed merger was read to the Supervisors.

"This change should be considered by the advisory boards of the hospital," said Supervisor Gordon L. McDonough, arguing against the proposal. "The committees are the only ones who can give us an impartial view of the situation at the institution."—Los Angeles *Times*, February 23.

* * *

Oregon Marriage Health Bill Vetoed

Salem (Ore.), February 25 (AP).—Governor Charles A. Sprague vetoed today a bill providing that the State Board of Health shall make free blood tests for marriage license applicants.—San Francisco *Examiner*, February 26.

* * *

Mass Insurance for Health

The new health insurance service projected by the California Medical Association makes an excellent beginning by placing at the head of its governing board Dr. Ray Lyman Wilbur, president of Stanford University, and a nationally recognized leader of the movement for a better distribution of the costs of medical care.

Doctor Wilbur is a pioneer in the movement.

He rendered extremely valuable public service through his work with the national committee investigating the high costs of medical care, and in the publication of the report of this committee.

That report has become a solid, factual foundation for the building of the movement for making modern medical care available to the great mass of Americans without disastrous financial sacrifice.

The movement gained headway slowly through the years. Like all new ideas, departures from old methods and traditions, it was unpopular. It aroused bitter antagonism. But with the backing of such men as Doctor Wilbur, it progressed. Necessity and logic were on its side.

The movement will progress much farther. We are seeing only its beginning now.

This community, headquarters of the hospital insurance movement for central California, can be proud that it has contributed something to this spread of better medical care at a lower cost.

As long as the movement is guided by such men as Doctor Wilbur and by others who have at heart the interests of both medical science and the mass of human beings who need its ministrations, it cannot fail to be constructive and an instrument of immense public good.—Oakland *Post-Enquirer*, February 6.

To Publish Report on Medical Survey

The California Medical Economic Survey, carried out in 1934 and 1935 at a cost of $100,000 and designed to give the facts regarding both private and public medicine and their relation to the economic picture in the State, is about to issue from the Graphic Arts Press in Washington, D. C. The survey was sponsored by the California Medical Association, the State Board of Health and the Federal public health agencies, the latter assuming two-thirds of the cost.*

Much of the research in the survey was handled by Dr. Ernest F. Penrose, associate professor of economics in the University of California on the Berkeley campus, and Dr. Paul A. Dodd, assistant professor of economics on the Los Angeles campus. Doctor Dodd investigated medical care as an economic problem, and Doctor Penrose studied the public health and insurance phases of the survey. Particular attention was paid to the condition and the costs of both public and private medical care in the State and recommendations were made to cover defects the survey disclosed.

An abbreviated copy of the survey was published by the California Medical Association. According to Doctor Penrose, the forthcoming volume is the first publication of the survey findings in full.—Berkeley *Gazette,* February 9.

* * *

Medico Plan Survey

San Francisco, February 14 (UP).—Dr. A. R. Kilgore and Allen W. Widenham, secretary and general manager, respectively, of the new California Physicians' Service, returned today after a survey of two medical service plans in the Pacific Northwest.

Prior to the inauguration of the "modified" socialized medicine plan being sponsored by the California Medical Association, they inspected the King County medical service plan at Seattle and the Oregon State medical plan.

The two men noted the present trend finds patients willing to pay sufficient sums to provide "complete coverage" for all ailments; that the great majority of patients served are of the low income group; that the aggregate return to physicians is not lowered but tends to be actually greater under prepayment service plans.

They said Northwestern doctors suffer no loss from uncollected accounts and that patients whose earning capacities are extraordinarily low are able to finance operations with no loss of self-respect or the incurring of debt as a result of the plan.

Report

In their report to trustees of the California plan, Doctor Kilgore and Widenham said that "open staff medical and hospital service plans are successful, smooth running and satisfactory in just the degree to which doctors and patients have a clear appreciation of their purposes and the objectives of the plan."

These aims, they said, could be attained through:

1. Removal of the financial barrier between patient and doctor.
2. Freeing the doctor from restrictions on use of hospital, x-ray and laboratory procedure imposed by the patient's inability to pay their costs.
3. Furnishing the most complete medical care possible and imposition of no restrictions upon the doctor in the care of his patients that are not absolutely necessary for establishment of these objectives with fairness to doctor and patient.—Alameda *Times-Star,* February 14.

* * *

Pottenger Urges Group Insurance

Compulsory health insurance was indorsed yesterday by Dr. Francis M. Pottenger, former president of the American College of Physicians and Surgeons, as "the only plan which will insure complete, stable income from all groups that need medical care."

In an address to the Town Hall Club in the Biltmore Hotel, the doctor, who is head of the Pottenger Sanatorium, Monrovia, declared:

"No matter what medical men may do, some form of medical insurance that will give satisfactory service to all is sure to come.

"I feel that this means compulsory insurance, and if the attitude of medical men is sympathetic, we will come nearer to getting what is right to serve the intended purpose when it does come."

His attitude, he added, is at variance with the opinion of the California Medical Society, of which he is a member.—Los Angeles *Examiner,* February 21.

* * *

Farm Bureau Members Hear Discussion of Pending Bills

Ray Wiser of Gridley, president of the California Farm Bureau Federation, led the discussion on the legislative program now before the State Legislature, including such items as hospitalization and medical care, especially to rural people, at a luncheon meeting in Red Bluff High School cafeteria today.

Sixty-five Tehama County Farm Bureau members attended, including representatives of each farm center who will take part in the spelling bee to be held at the Show Boat February 25.

President Wiser said Senate Bill No. 1128 dealt with the matter of hospitalization and medical care. Assembly Bill No. 2499, which would liberalize the present act regarding county hospitals, he said, would permit the admission of part-paying and paying patients to county hospitals and also provide for proper investigation of such cases and permit any doctor to enter the county hospital to treat patients when such patients request it.

He also discussed hospital and health insurance, and stated Assembly Bills No. 2501 and No. 2494, sponsored by Assemblyman Garland of Tulare County, which deal with hospital and health insurance, would attempt to set up suitable working plans whereby hospitals and health insurance can be provided to those who are unable to pay for their own under present conditions.

Wiser quoted the Surgeon-General of the United States as stating that this country could reduce its sickness by 70 per cent in one generation by simply making it mandatory for people generally to have proper medical care.—Red Bluff *News,* February 11.

LETTERS

Subject: Bequest of late Walter Jarvis Barlow, M. D., to the Los Angeles County Medical Association Library.*

(COPY)

CALIFORNIA COMMUNITY FOUNDATION
SECURITY-FIRST NATIONAL BANK OF LOS ANGELES
TRUSTEE

Los Angeles, California,
January 23, 1939.

To the Editor:—Your letter of January 17, asking information concerning the gift of the late Dr. Walter Jarvis Barlow to the library of the Los Angeles County Medical Association has been received.

The following is an excerpt from Doctor Barlow's will:

> I give and bequeath the sum of ten thousand dollars ($10,000) to Security-First National Bank of Los Angeles, a national banking association, with its principal place of business at Los Angeles, California, and its qualified successors, in trust for the charitable uses and with the powers and duties both as to principal and income which are fully set forth in a resolution recorded in Book 242, page 182, of Miscellaneous Records of Los Angeles County, adopted on the first day of June, 1915, by the board of directors of Security Trust and Savings Bank, which on April 1, 1929, duly merged into or consolidated with said Security-First National Bank of Los Angeles, providing for a community charitable trust designated in said resolution as Los Angeles Community Foundation, which said resolution is incorporated herein by reference with the same force and effect as if herein set forth at length.
>
> It is my request that the said set income be distributed in quarterly or other convenient installments to the Los Angeles County Medical Association of Los Angeles, California, to be used for medical library purposes so long as said Los Angeles County Medical Association shall exist and continue to maintain a medical library. In the event that the purposes and objects above mentioned should at any time fail or said Trustee be unable to apply, expend and disburse said net income for said purposes, then it is my request that thereafter the net income from said trust fund shall in perpetuity be paid in quarterly or other convenient installments to the Barlow Sanatorium Association, a charitable corporation, of Los Angeles, California, to be used for its general purposes. In none of the cases in this Article mentioned shall the Trustee be required to see to the application of said funds for the purposes herein specified, but the receipt of the proper officer or custodian of Barlow Medical Library or the Library of Los Angeles County Medical Association, or the proper officer of said Barlow Sanatorium Association, as the case may be, shall be sufficient discharge of the Trustee therefor.

From this excerpt you will see that the bequest was not to the library direct, but to the Security-First National

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* Actual figures from California Medical-Economic Survey, on page xx, are: California Medical Association, $46,126.84; Federal Government, $55,425.42.

* See also editorial comment, page 172.

Bank of Los Angeles, Trustee for the Los Angeles Community Foundation, which is now known as the California Community Foundation. The amount of the bequest was $10,000 and the check for $210 tendered in the Foundation's letter of December 30, 1938, to the Los Angeles County Medical Association for medical library purposes, represented the first payment of income made pursuant to the Decree of Distribution. It is the expectation that further payments will be made quarterly.

You may be interested in the accompanying copy of the California Community Foundation's booklet, which explains the purposes for which it was founded and the scope of its activities. In 1928 Doctor Barlow was selected to be a member of the Foundation's first Advisory Committee, and until his death on September 4, 1937, he served on the committee, taking an active and constructive part in all its affairs.

Should an article concerning this gift by Doctor Barlow appear in your publication, CALIFORNIA AND WESTERN MEDICINE, I should very much appreciate your sending me two copies for my files.

It is indeed a pleasure to give you these data, and should you at any time desire more information concerning the California Community Foundation, I shall be glad to supply it.

215 West Sixth Street.

Very sincerely yours,
(MISS) LOUISE BENNETT,
Secretary, California Community Foundation.

Subject: A California Medical Association member's comments on California's state-wide voluntary medical service plan.

Fresno, California.
February 24, 1939.

To the Editor:—The doctors of the country will probably never completely agree on *a* method or plan for furnishing medical service. Proverbially, doctors do not agree. There are too many "rugged individualists" among them. Some three thousand plans and experiments are now being tried in the United States. No one plan, probably, can ever be adapted to meet the varying needs and conditions prevailing in our great country, with the multitude of factors to be considered, such as climate, employment, housing, density of population, medical and hospital facilities, varying nationalities and races, transportation facilities, etc. But certain general and fundamental principles for such plans have already been accepted by the American Medical Association. Free choice of physician, preservation of patient and doctor confidential relationship, reasonable compensation for services, and elimination of political control, are some of the essentials. To this might be added flexibility of the plan so as to permit changes warranted by accumulated experience, and development of new needs for service. Our California Physicians' Service, which will be launched shortly, has all these essential features. It was adopted by an almost unanimous vote by the representatives of the six thousand members of the California Medical Association and, if accepted as generally by the profession throughout the state, it will be a new high point for agreement among the doctors.

The California Physicians' Service is the most extensive experiment in distribution of medical and hospital service in this country. Many years of study and planning by earnest, clear thinking members of the California Medical Association have evolved this plan of service. It should and must succeed. It is hoped it will provide needed services for those whose low incomes make payment of doctor bills a hardship, and enable the thrifty to budget medical costs in a simple practical way. (A recent Gallup poll, on voluntary health insurance, showed that some twenty-five million people, largely in a group earning over $980 a year, were willing to pay $3 a month for complete medical and hospital care.)

It is also hoped that the threatened organization of *all* medical service on a taxation or compulsory insurance basis will not find many supporters when this medical service is made generally available. It is also thought that the flexibility of this plan of service will permit government agencies to arrange for the care of groups now a taxpayers' burden, and make some provision for compensation for medical care now donated by our profession. Some definite assurances from leaders of the farm organizations of the state make it very probable this service will appeal to the rural population and will answer their demand for "group practice" and medical service on the prepayment basis. The availability of this service is also eagerly watched for by many employers, who are trying to make provisions for their employees against the contingencies of sickness and hospital expense. Many employers now using commercial insurance contracts for this purpose find these insurance policies so restricted and limited that a full coverage such as is contemplated by California Physicians' Service will offer the needed protection. The 35 to 40 per cent profit charged by commercial companies also makes a poor comparison with a nonprofit organization with an estimated 10 per cent administration cost. Labor organizations, city employees, industrial groups, and individual wage-earners will, in many instances, welcome the opportunity to provide against the cost of ill health and the flexible features of the Service will, I believe, enable us to offer what these people need and can afford to pay for.

Now that we have committed ourselves to offer this Service to the public, we must give it whole-hearted support and, if possible, make it such a success that it may serve as a pattern for other states. Adjustments and changes will be necessary as experience shows the need. These can be readily made, and improvements added as required.

Some of the immediate problems to be met, such as the patient demanding hospitalization and surgery for some chronic ailment or elective surgical condition, may cause some difficulties during the first few months, as shown by the San Francisco Municipal Employees' Service. But experience gained there will help us meet this situation. About 95 per cent of our people are reasonably honest. Impositions and demands for unnecessary service will come from about 5 per cent of beneficiary members. Coöperation on the part of the doctors rendering service will keep the expense from this source at a minimum. Unfortunately, the percentage of honesty is no greater for the practitioner of medicine. Chiseling will occur, but there are many safeguards against unfair practices by the professional members, and I believe it will prove no serious problem. One of the primary requisites for success of this service is sufficient spread of beneficiary members to provide the funds for the risks involved. I believe every member of the California Medical Association should help promote and advertise this Service to all of his clientele entitled to enroll as a beneficiary member. There should be no hesitation about recommending it to patients who pay their bills if they are in the proper income classification. The doctor will be remunerated for his services on a unit of service basis, but experience again has already provided a guide which will permit returns to the doctor of at least the usual fees for his services. It is possible, of course, that during the initial period of some months the returns may be less, but we should accept this possibility with no great flurry of disappointment, as provisions have already been made to reimburse for the lean early months by payments from later surplus receipts. The average income of the general practitioner in the United States is only $3,500 per year. The total cost to the country for medical service is about three and a half billion dollars. It is estimated that the administrative cost of any compulsory or tax-supported medical service would be another billion dollars. The compulsory health insurance proponents offer better incomes for the doctors to enable more frequent postgraduate courses of study and thus provide an improved medical service. Our already overloaded tax burden would be increased by another billion or two on this score.

Political appointees would, under any form of state medicine, dictate to the profession. Bureaus and red tape are a part of such a system. Malingering and pseudo-illness on the part of the public have always developed. Increased and unnecessary hospitalization always increases the cost. The quality of medical service has always deteriorated. Free choice of doctors and hospitals is impractical and impossible. Records of ailments become public property. Political control and graft is unavoidable.

If, therefore, we can make a success of our Physicians' Service and satisfy the clamor for social changes in the methods of distributing medical and hospital care, we will not only preserve to ourselves the essential elements of the private practice of medicine (for which as yet no superior system has been found) and perhaps escape the regimentation and odious conditions of compulsory State Service practice but do a great service to the taxpaying public and still assure our people of the best medical care offered anywhere in the world.

Medical Group Building.

Respectfully submitted,
Axcel E. Anderson.

Subject: Opinion of California Attorney-General on legal right of licentiate to aid an unlicensed practitioner.

420 State Office Building,
Sacramento, California,
February 20, 1939.

To the Editor:—Enclosed please find copy of Opinion No. NS1409, rendered by the Attorney-General on February 9, 1939, which we thought might be of interest for publication in California and Western Medicine.

Very truly yours,
C. B. Pinkham, M. D.,
Secretary-Treasurer.

* * *

(copy)

State of California
Legal Department

San Francisco, February 9, 1939.

Charles B. Pinkham, M. D.,
Secretary-Treasurer,
Board of Medical Examiners,
420 State Office Building,
Sacramento, California.

Dear Sir:

In your communication of January 3, 1939, you enclosed a copy of a letter written you by Special Agent W. N. Anderson, wherein he requests an opinion as to whether the conditions set forth in his letter warrant charging a licentiate with aiding and abetting an unlicensed practitioner or with practicing under a fictitious name. You request that such an opinion be forwarded to you.

From the facts disclosed in Mr. Anderson's communication, two unlicensed men own a sanatorium essentially for the treatment of alcoholism, and employ a licensed physician and surgeon "as a medical director." The latter is paid a salary of $200 a month and as such medical director handles all cases coming into the sanatorium.

In reply, please be advised that a licensed physician and surgeon cannot render medical services to patients of unlicensed persons in consideration of a salary paid to him for so doing. In *People* vs. *Painless Parker, Dentist* (Colo.) 275 Pac. 928, the defendant corporation employed dentists to render professional services and the court held that it was too clear to require discussion that the defendant corporation was engaged in dental practice when it selected natural persons to extract teeth, diagnose conditions of patients, and perform dental surgery.

In *Masters* vs. *Board of Dental Examiners,* 15 Cal. App. (2d) 507, the licensed person was charged with having aided and abetted an unlicensed person, to wit: the Western Health and Hospital Corporation, Ltd., a corporation, to practice dentistry, by knowingly accepting employment from such corporation to perform dental operations and give dental treatments for such corporation, such corporation, to the knowledge of Doctor Masters, offering to perform operations upon and treat diseases of the human teeth, etc. The order of the Board revoking the license of Doctor Masters was affirmed, the latter unsuccessfully urging that the accusation did not state facts sufficient to constitute unprofessional conduct or warrant the suspension or revocation of his dental license.

Again, in *Granger* vs. *Adson,* et al. (Minn.), 250 N. W. 722, the Supreme Court of Minnesota indicated:

"What the law intends is that the patient shall be the patient of the licensed physician, not of a corporation or layman. The obligations and duties of the physician demand no less. There is no place for a middleman."

It would hence appear that if the institution advertised, offered to treat, or treated a sick or afflicted person, alcoholic or otherwise, the licensed employee would be guilty of aiding and abetting an unlicensed person in the practice of medicine.

A closer question exists as to whether a licensed person receiving a salary from laymen for handling patients of such laymen would be practicing under a fictitious firm name, where the institution advertised under a name such as "Health Sanatorium." Provided the institution held itself out as rendering medical services, such fact might constitute, in point of law, the adoption of such name by the licensed person, where the latter, with such knowledge, continued to render medical services for the institution.

Such was the fact in the case entitled *Berry* vs. *Alderson,* 59 Cal. App. 729, where the licensed person adopted the name "K. B., Bloodless Surgeons," a name other than his own, in connection with his practice. Such was likewise the case in *Grisso* vs. *Board of Medical Examiners,* 75 Cal. App. 385, where the licensed person filed a certificate indicating that he was the sole owner of "Bohannon Cancer Institute" and was doing business under that name.

Mr. Anderson's communication also asks if two laymen may obtain an institution license and hire a medical man to handle all cases therein requiring treatment of the sick and afflicted.

In reply, please be advised that the licensing of private institutions is covered by Chapter I, of Part 2, Division 6, of the Welfare and Institutions Code. Section 5700 thereof prohibits persons who have not first obtained a license from the State Department of Institutions from conducting such institutions. The section referred to, and those following, are concerned with the physical aspects of the premises, the capacity of the buildings, the extent and location of the grounds appurtenant thereto, and the number of patients proposed to be received therein, rather than with the personnel thereof. Consequently, the first portion of such question may be answered in the affirmative, there being nothing in said sections to prevent a layman from securing such a license.

The second portion of such question must, however, be answered in the negative, as the unlicensed owners of such an institution cannot hold themselves out as rendering medical services and hire a licensed physician to render such services for them.

The Supreme Court, in the case of *Painless Parker* vs. *Board of Dental Examiners,* 216 Cal. 285, indicated that on grounds of public policy a corporation could not manage, conduct or control the licensed dentist and term it "the business side" of the practice of dentistry, as such profession could not be divided into departments.

Very truly yours,
EARL WARREN, *Attorney-General.*
By Lionel Browne (Signed), Deputy.

Subject: "May Day"—Children's Bureau of United States Department of Labor.

UNITED STATES DEPARTMENT OF LABOR
CHILDREN'S BUREAU
WASHINGTON
February 9, 1939.

To the Editor:—I am enclosing, for your information, copies of suggestions in connection with May Day—Child Health Day, 1939, which have been forwarded to the health officer and May Day chairman of each state. You will note that all of the material emphasizes the need for medical care for children.

Whether or not the enclosed suggestions on nutrition are used will depend upon the decision of State May Day committees, since each state emphasizes in its Child Health Day plans the subjects that will be most helpful in rounding out its own child-health program. We shall be glad to send additional copies of the material if desired. . . .

Sincerely yours,
MARTHA M. ELIOT, M. D.,
Assistant Chief.

* * *

United States Department of Labor, Children's Bureau,
Washington
MAY DAY—CHILD HEALTH DAY, 1939
Monday, May 1
Suggestions for Observance

Child Health Day activities are sponsored by the Children's Bureau at the request of the State and Provincial Health Authorities of North America in accordance with the Congressional Resolution of May 18, 1928, which authorized the President to proclaim May Day as Child Health Day.

Slogan: The health of the child is the power of the nation.

Objective: To bring to the attention of each community—The importance to the child's health, development, and well-being throughout life, of proper food, rest, exercise, medical care, and protection against disease; the ways of informing parents and others how child health may be safeguarded; and the means whereby such safeguards may be made available for all children.

Leadership: State May Day chairmen and representative State May Day committees appointed by State health officers. State departments of education coöperate in planning school Child Health Day programs.

Program: The State May Day Committee decides upon the Child Health Day emphasis that will best contribute toward strengthening the year-round child health program. Community groups arrange for the presentation to the public of child health needs in the community, for planning by interested groups of joint efforts for advancing child health during the year, and for launching new child health projects. School children, as a climax to the year's health education program, show by exhibit, demonstration, programs, and plays what they have learned about safeguarding their own and the community's health, and celebrate in festivals and games progress made during the year.

For State programs write to May Day Chairmen, State Departments of Health.

* * *

What is your community doing to promote good nutrition of mothers and children? An outline for a survey
to be made in preparation for
MAY DAY—CHILD HEALTH DAY, 1939

(*a*) *Health Services*

Through: Family physicians; specialists in obstetrics and pediatrics; public health nurses; maternal and child health conferences; school health supervision; food protection; health camps; hospitals; children's institutions.

1. Check the above health services available in your county or community. Are there others?

2. Can all expectant and nursing mothers obtain reliable information on their food needs? Where?

3. Can all mothers obtain health supervision for their babies and growing children? Does this health supervision include information on food needs of children?

4. Do most of the mothers in the community know that these services are available? Do those that need these services most take advantage of them?

5. Are vacation camps, nursery schools, special classes, or other facilities available for improving the condition of undernourished children?

6. Do hospitals, maternity homes, and child-caring institutions have consultation service (if not full-time service) from a trained dietitian?

7. Are the nutritive quality and cleanliness of milk and other essential foods sold in the community insured through adequate legislation and regulation?

8. Is the nutrition of children safeguarded by other health services? Specify.

(*b*) *Educational Programs*

Through: Health agencies; schools; adult education classes; home demonstration clubs, boys' and girls' organizations.

1. Check above health education opportunities in your community.

2. Can newly married couples and young parents obtain systematic instruction in the relation of everyday food practices to health?

3. Can mothers, foster mothers, and individuals engaged in feeding children in groups obtain systematic instruction in food production, food purchasing, menu planning, food sanitation, and food preparation? Is emphasis placed on the relation of these activities to the health and pocketbook of the family?

4. Do public and private schools offer a comprehensive program of health instruction that reaches all students?

5. Do schoolboys and schoolgirls who present special nutritional problems receive attention and care according to their individual needs?

6. Do the schools consider the feeding of children at school as part of the health education program? As such, is it supervised by a worker who knows the nutritional needs of children?

7. Is the sale of unsuitable foods on the school premises forbidden as contrary to a sound program of nutritional education?

8. Do boys' and girls' organizations stimulate interest in good nutrition as an end in itself as distinguished from interest in competitive awards for health achievement?

9. Do health agencies and educational agencies coöperate in spreading sound information on nutrition? Do they help the public to discriminate between sound and unsound information that is disseminated from other sources?

10. Is the nutrition of mothers and children promoted by other educational programs?

(*c*) *Economic Assistance*

Through: Public and private relief agencies; emergency relief agencies—e. g., WPA, NYA, FSA; service clubs; churches.

1. Do dependent families receive sufficient assistance (cash, grocery orders, commodities, garden seeds, etc.) to enable them to have an adequate diet?

2. Do allowances to dependent families provide for the special needs of expectant and nursing mothers, growing children, and undernourished individuals of all ages?

3. Do families and individuals who receive public assistance receive also information that will enable them to obtain an adequate diet on their food allowance?

4. Are families helped to increase their own food supply through planting home or community gardens, canning and storing food surpluses, and taking advantage of other opportunities for home food production?

5. Do child-caring institutions in rural areas take advantage of the opportunity to improve their food supply and keep down the cost through producing part of their food supply?

6. Where climate permits do rural schools maintain gardens to furnish vegetables for the school lunch?

7. Are plans made so that school children who are not able to pay for a lunch at school are provided with lunch without having it known that they cannot pay?

8. Are families and individuals helped in other ways to get an adequate food supply?

SUMMARY

1. What community activities are promoting good nutrition for mothers and children?

2. Which of the efforts to promote good nutrition in the community are most effective?

3. What are the outstanding shortcomings in the community activities that relate to nutrition?

Subject: Seal sale of the California Tuberculosis Association.

San Francisco, February 1, 1939.

To the Editor:—The Board of Directors of the California Tuberculosis Association has asked me to extend to you their sincere appreciation for the article concerning the work of our association and the importance of the Christmas Seal sale carried in California and Western Medicine for the month of December.

Early returns in California indicate a banner Seal sale—one which will probably exceed our successful 1937 sale.

We feel that your service has played a part in winning for us this whole-hearted support of the general public.

45 Second Street.

Sincerely yours,
W. F. Higby, *Executive Secretary.*

Subject: "California State Humane Pound Act"—Proposed 1938 Initiative Law No. 2.

(copy)

California Society for the Promotion of Medical Research

San Francisco, February 10, 1939.

Memorandum to: Drs. Wilbur, Lucia, Meyer, Gilman, and Kress.

From: William F. Benedict.

The archives of the campaign to defeat the State Humane Pound Act are in shape and installed in three transfer cases which will be deposited in the Archives Room at the University of California by authority of the Executive Committee as soon as material necessary to complete the final report has been received from the various county medical societies.

The scope of the files is shown on the attached list of subject headings, which I felt you would like to retain for future reference.

William F. Benedict.

* * *

Archives of California Society for the Promotion of Medical Research—Subject Headings in Files

Advertising Schedules and Copy.
American Medical Association.
Antivivisection Organizations and Propaganda.
By-Laws of California Society for the Promotion of Medical Research.
California Medical Association.
Committees—Northern California.
Committees—Southern California.
County Organization—Northern California.
County Organization—Southern California.
De Kruif, Paul—Reprints, et cetera.
Dentists' Coöperation—Dental Societies.
Diseases—Material re.
Drug Manufacturers and Dealers.
Endorsements and Resolutions.
Executive Committee.
Finance Committee.
Finance Reports.
Forms and Form Letters.
Hearst Newspapers
Hospitals—Miscellaneous.
Individuals and Organizations.
Insurance—Miscellaneous.
Laboratory Rules—Vivisection Procedure.
Legal Opinions.
Letters of Solicitation for Finances.
Literature—Distribution of
Los Angeles County.
Medical Colleges.
Medical Societies.
Motion Pictures.
Newspaper Lists and Correspondence.
Nurses' Association.
Out-of-State Medical Leaders.
Pamphlets, Booklets, et cetera.
Past Campaigns—Data re.
Press Releases—Southern California.
Propaganda—Pro-Medical.
Public Health League of California.
Publicity Material—Original Statements.
Radio—Miscellaneous.
Requisitions and Orders for Materials.
San Francisco County.
Scientific Publications.
Speakers' Manual.
Speeches, Statements and Articles.
Stanford University Coöperation.
Statement to the Voters.
Stock Raisers—Interest of.
Women's Auxiliaries.
Speakers' Manual and Supplements—Extra Copies.
Final Campaign Reports—Extra Copies.

Subject: Correspondence from London, regarding a Los Angeles chiropractor.

(copy)

Rosary Gardens
South Kensington, S. W. 7
London
January 6, 1939

To the Secretary of the California Medical Association,
San Francisco, California.

Dear Sir:

I must apologize for troubling you—but I should be very grateful if you could help me.

During last summer I came in touch with Dr. ——— of Los Angeles when she was in London, and became very interested in her treatments by her radiotherapy instrument. I took my little daughter to see her, as she is a backward child and not a case for the ordinary practitioner.

Doctor ———, with the aid of her instrument, diagnosed the trouble as caused by a malformed pituitary gland and feels that regular treatment with one of her instruments would probably help the child very considerably.

It is almost impossible over here to find out much about the results of her treatment, as she was only over—I believe for the first time—this summer, and it would take some time before the effects of the treatment would show themselves in a case like our daughter's. We are naturally anxious to help our child in any way we can, but feel that we should know more about this treatment before trying it for her.

We should be most grateful if you could advise us and if you could tell us of any similar cases that have been helped by Doctor ——— treatment.

I am, dear sir,
Yours truly,
(Signed): Mrs. ———————.

* * *

San Francisco, California
January 31, 1939
Yours of January 6
Re: ———, D. C.

Mrs. ———
Rosary Gardens
South Kensington, S. W. 7
London, England

Dear ———:

Your letter of January 6, addressed to the Secretary of the California Medical Association, has been forwarded us for reply.

You stated therein that you became interested in Dr. ———, when she was in London, with her radiotherapy instrument, following the diagnosis made by said Dr. ——— and her machine of your little daughter, described as a backward child. You relate that "Dr. ———, with the aid of her instrument, diagnosed the trouble as caused by a malformed pituitary gland" and advised you that "regular treatment with one of her instruments would probably help the child very considerably."

Our records show that Dr. ———, a graduate of the Los Angeles College of Chiropractice, December 21, 1926, is licensed by the Board of Chiropractic Examiners to practice "chiropractic." So far as we know, she has no medical training. Our records indicate that for the past three or four years she has been operating the "——— Laboratory of Radiotherapy—Home of the Homo-Vibra Ray, ———, Los Angeles." She is said to operate "a sort of laboratory and clinic," using the "homo-vibra ray" (whatever that may be) and other so-called radio modalities, one of which is known as the "——— Short Wave Outfit," which assertedly diagnoses and treats all diseases.

One informant reported at our Los Angeles office September 30, 1938, that she consulted ———, "who she says is diagnosing and treating by radio. The patient puts a drop of blood on a piece of blotting paper and sends it to Mrs. ———, who makes her diagnosis from this specimen."

Our informant related that "One patient, who is in the East some place, sent a drop of blood and ——— diagnosed this case as broken ribs, the fourth and fifth ribs."

The last-mentioned report indicates the possibility that ——— is using an electrical appliance similar to that of the old Abrams electronic machine (also called an oscilloclast), a totally unscientific apparatus, which was the subject of an article printed in the *Journal of the American Medical Association,* September 20, 1924, page 939; also in the *Scientific American,* October, 1923, issue.

Very truly yours,
C. B. Pinkham, M. D.,
Secretary-Treasurer.

Subject: American Physicians' Art Association.

San Francisco, February 10, 1939.

To the Editor:—The American Physicians' Art Association, composed of over seven hundred physicians throughout the country who have become proficient in all kinds of art work as an avocation, will conduct their second art exhibit at the City Art Museum of St. Louis next May during the convention of the American Medical Association.

In order to bring this matter to the attention of thousands of your subscribers, we are hoping that you may arrange to publish the notice below in an early issue of your noted and valued journal. Please notice that the *Journal of the American Medical Association* has already published such a notice in their issue of February 4, 1939, Vol. 112, No. 5, page 456.

Thanking you in advance for such a courtesy and hoping you may be able to send us a copy of the issue that may contain such a notice, I beg to remain

521 Flood Building.

Respectfully yours,
Francis H. Redewill, M. D.,
President.

"The American Physicians' Art Association, composed of members in the United States, Canada, and Hawaii, will hold its second Art Exhibit in the City Art Museum of St. Louis, May 14 to 20, 1939, during the annual session of the American Medical Association. Art pieces will be accepted for this art show in the following classifications: (1) oils, both (a) portrait and (b) landscape; (2) water colors; (3) sculpture; (4) photographic art; (5) etchings; (6) ceramics; (7) pastels; (8) charcoal drawings; (9) book-binding; (10) wood carving; (11) metal work (jewelry). Practically all pieces sent in will be accepted. There will be over sixty valuable prize awards. For details of membership in this Association and rules of the Exhibit, kindly write to Max Thorek, M. D., Secretary, 850 Irving Park Boulevard, Chicago, Illinois, or F. H. Redewill, M. D., President, 521-536 Flood Building, San Francisco."

MEDICAL JURISPRUDENCE†

By Hartley F. Peart, Esq.
San Francisco

OPERATIONS UPON PERSONS LEGALLY INCOMPETENT TO CONSENT TO SAME

It is a general rule of law that a physician or surgeon cannot operate upon a person without his express or implied consent, or if the person to be operated upon is legally incapable of consenting, then without the express or implied consent of one legally competent to consent for him.

Two classes of persons who are, by law, incompetent to give consent are minors and mentally incompetent adults. Consent to operate upon such persons must be obtained from the person duly appointed to act as guardian, or in the case of minors with living parents, from the parents, since they are, in point of law, natural guardians of their children. In early days, another class was recognized, namely, wives. Consent of the husband was necessary then, due to the fact that the wife and husband were considered as one entity, and the husband had the sole right to contract for anything affecting that entity. Today the laws of this and most other states grant to a wife equal rights in regard to binding oneself by contract, and apparently to consenting to surgical operations.

Since two elements, implied consent and emergency, are constantly used to create exceptions to the general rule requiring consent, one can only reach a conclusion as to what a court may do in a particular instance by reviewing decisions handed down in the past.

Typical instances of the application of the general rule are the following:

In *Zoski* vs. *Gaines,* 271 Mich. 1, 260 N. W. 100, defendant physician removed the tonsils of a nine-year-old boy without consent of his parents and at a time when no emergency existed. Defendant was held liable to the boy's parents.

In *Moss* vs. *Risworth,* 222 S. W. 225, a physician was held liable for a similar operation upon an eleven-year-old child although he was accompanied by an adult sister.

And in *Pratt* vs. *Davis,* 224 Ill. 300, 79 N. E. 562, 7 L. R. A. (N. S.) 609, it was held that consent by a man to an operation upon his insane wife for the removal of her uterus and ovaries is not shown by the fact that, after an operation of a minor nature to which he consented, which did not prove successful, he complied with a direction to bring his wife again to the surgeon for treatment.

Evidencing judicial treatment of the question of implied consent, the following cases are enlightening:

In *Theodore* vs. *Ellis,* 141 La. 709, 75 So. 655, the decision in favor of a patient who lost forever his manhood powers by reason of the unnecessary performance of an operation, was based largely upon the ground that he would not have consented if the doctor had informed him concerning, or prescribed, as he failed to do, a well-recognized remedy which might have afforded the desired relief.

In *Van Meter* vs. *Crews,* 149 Ky. 335, 148 S. W. 40, it was held that the conclusion would have been warranted that there was an understanding that the surgeon might operate if he found it necessary to do so, the matter having been talked over with relatives at the hospital as well as with the patient herself.

In *Bakker* vs. *Welsh,* 144 Mich. 632, 108 N. W. 94, 7 L. R. A. (N. S.) 612, it was held that a father could not complain because his express consent had not been procured for an operation on his seventeen-year-old son for a tumor, where the operation was not of a very dangerous character and there was nothing to indicate to the doctors, before proceeding to operate, that the father did not approve of his son's going with his aunt and adult sisters to consult one of the doctors and following his advice.

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† Editor's Note.—This department of California and Western Medicine, presenting copy submitted by Hartley F. Peart, Esq., will contain excerpts from and syllabi of recent decisions and analyses of legal points and procedures of interest to the profession.

Thus it can be seen that, although a physician is allowed to proceed when the words or actions of the patient or guardian imply acquiescence, the physician should always obtain a commitment more definite than a mere retained for examination and treatment.

Emergency, the other element granting to physicians a certain amount of freedom to act as he thinks best, is usually a proper defense if actually present.

In *Luka* vs. *Lowrie,* 136 N. W. 1106, 41 L. R. A. (N. S.) 290, a fifteen-year-old boy had his foot crushed by a train. Hospital physicians thought amputation necessary before the parents, who lived across town, could be reached. The court held that their consent was not necessary due to the existing emergency.

In *Jackovach* vs. *Yocum,* 237 N. W. 444, plaintiff, a boy of eighteen years, fell off a train, suffering a severe gash in the head and a mangled arm. While under an anesthetic given to enable the gash to be sewn up, the surgeons concluded that amputation of the arm would soon be necessary and made amputation immediately to avoid a second shock to the boy's system, which would necessarily occur if ether should be given to him again. It was held that the danger to the boy's life, created by the emergency, was a defense.

However, in *Franklyn* vs. *Peabody,* 249 Mich. 363, 228 N. W. 681, it was held that the unauthorized removal of fascia or membranous tissue from the thigh of a patient, in order to afford sheathing for the tendons of his finger, which were found to be adhered together, could not be justified upon the theory of an emergency, since the primary operation on the patient's stiff finger was in no sense a major one; and in *Mohr* vs. *Williams,* 95 Minn. 261, 104 N. W. 12, 1 L. R. A. (N. S.) 439, it was held that no emergency existed such as would justify operating without the patient's consent, nor was implied consent shown where only one ear had troubled the patient and the surgeon had given assurance that the other was in good condition, but, when about to operate on the one which troubled the patient, the surgeon discovered that it did not require an operation, and then immediately proceeded to operate upon the other, which he found to be in bad shape, no objection being made by the patient's family physician, who was present.

It should be stated that the courts have sometimes made a distinction where the patient is a minor and old enough to be capable of understanding. For instance, in *Bishop* vs. *Shurly,* 237 Mich. 76, 211 N. W. 75, a nineteen-year-old fatherless boy was taken by his mother to a physician's office for examination. The physician recommending a tonsillectomy, the mother specified a general anesthetic. At the time of the operation the boy requested a local anesthetic, which was given without the mother's knowledge. He died on the operating table. The Court held that the physician was not liable and stated that a nineteen-year-old boy may contract for necessities without parental consent. This was a Michigan case and, although it probably would be followed in California, too much reliance should not be placed upon it. The *Bakker* case, referred to earlier, is also interesting in this regard.

From the foregoing cases and from other decisions examined, the following conclusions may be drawn:

1. If no emergency exists and if the patient is a child under the age of sixteen (this is not an arbitrary age limit), it is absolutely necessary for the physician to secure consent of the child's parent or guardian before undertaking a major or minor surgical procedure. Failure to obtain consent will render the physician liable for assault and battery.

2. If the patient is under the age of 21, but over 16 or 17, a minor surgical operation may be performed without the express consent of the patient's parent or guardian even though no emergency exists. The cases supporting this rule are of such a nature that it is recommended that caution be used by all physicians.

3. If an emergency exists and it is necessary to resort to emergency or minor surgery in order to save the patient's life, the physician may safely proceed without first obtaining the consent of the patient's parent or guardian even though the patient is a child of tender years. This rule, however, is restricted to extreme cases. In other words, the emergency must be a real one.

4. The law makes no distinction between major and minor surgery except where minor surgery is employed upon a boy or girl seventeen years of age or over.

5. In the case of insane persons, a physician should always procure consent from the guardian, unless there is an acute emergency.

SPECIAL ARTICLES

INDEX

1. *Report of Los Angeles County Grand Jury: Los Angeles County Hospital, Alameda County Institutions Commission.*
2. *Report of Surgeon-General of United States Public Health Service.*
3. *Proposed Public Health Legislation for California.*
4. *California Physicians' Service: Questions and Answers.*
5. *Twenty-five Years Ago.*
6. *California Board of Medical Examiners.*

LOS ANGELES COUNTY HOSPITAL:[*] ALAMEDA INSTITUTIONS COMMISSION[†]

(COPY)

Report of the Charities and Health Committee of the 1938 Grand Jury of Los Angeles County

To the Foreman and Members of the 1938 Grand Jury:

The members of this committee consist of the following: William W. Nuzum (chairman), Harvey S. Black, Charles G. Van Hook, Mrs. Sarah Frank, Mrs. Mary Ethel Robb, William Arthur Tucker, Mrs. Pauline Case.

Among the various duties assigned to this committee was an inspection and a study of the various county departments commonly charged with the administration of charities and health functions. Pursuant to that delegation of authority, your committee has made a tour of inspection of the Olive View Sanatorium, the Los Angeles County General Hospital and the Rancho Los Amigos County Farm. Various items of relative importance were noted and comments made to the heads responsible for the respective departments, with a view of improving conditions where such improvement was, in the opinion of your committee, necessary or desirable.

ADMITTING DEPARTMENT OF THE LOS ANGELES COUNTY HOSPITAL

Particular attention was given to the conditions at the Los Angeles County General Hospital. It was noted, among other things, that the present facilities of the Admitting Department were inadequate to take care of patients in a proper and humane way. It was found by your committee that, on various occasions, many seriously ill patients were kept waiting in the admitting room hours before they were sent to a ward where proper and competent care could be given them. This matter was discussed with the hospital authorities, and particularly with the admitting physician in charge of that department. It was considered that some of the available space, adjoining the space occupied by the Admitting Department, could be utilized for the purpose of enlarging the facilities of that department. At the suggestion of your committee, the hospital adopted the plan of increasing the facilities of the Admitting Department so that patients, who formerly would have been required to spend some time in the admitting room before they could be transferred to a ward, are now placed in a regular hospital bed in a room immediately adjoining the Admitting Department. After several months' operation of this new feature, your committee has been informed that patients are handled with greater dispatch and without any increase in the number of persons employed.

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[*] For articles and comments on the Los Angeles County Hospital and Institutions Commissions, see CALIFORNIA AND WESTERN MEDICINE in following issues: February, 1938, page 73; February, 1938, page 97; March, 1938, page 156; March, 1938, page 216; March, 1938, page 225; April, 1938, page 300, and May, 1938, page 383.

[†] For references to the Alameda Plan and Institutions Commission, see following issues: October, 1931, page 315; October, 1931, page 331; November, 1932, page 324; November, 1932, page 330; November, 1932, page 354; July, 1933, page 1; November, 1933, page 340; and June, 1938, page 395.

EXISTING ERRORS IN ADMINISTRATION

The audit report submitted to the Grand Jury by Eugene M. Berger reveals a number of situations which call for immediate action. Because the report is complete in all of the details relating thereto, no specific mention is considered necessary in this report of all of the items covered. Some of the outstanding situations to which our attention was called by the audit report—which, by reference, is made a part of your committee's report—are as follows:

1. Excessive charges to patients.
2. Increase in total number of persons employed, and increase in cost per employee.
3. Lack of discipline of the hospital personnel.
4. Dilatory practices in admitting patients, and in transferring them to other institutions.
5. Piling up of an unusual amount of work in the technical departments.
6. Failure on the part of interns and residents to perform their functions properly.
7. The unsatisfactory condition created by failure to exercise proper supervision over the attending staff.

The disclosures called to our attention were carefully considered, as were the recommendations submitted for their correction, with the result that your committee now recommends:

1. *That the present policy of billing all patients indiscriminately be abolished.*

Your committee feels that whatever charges should properly be made against the indigents for care given them at a hospital should be that amount which, in the judgment of the Social Service Department, constitutes a fair and reasonable charge in keeping with the indigent's ability to pay. In order to carry out this program, your committee further recommends:

2. *That no charges be made and no security be exacted from the indigent except upon the approval of the Social Service Department.*

At the present time, the Social Service workers attached to the hospital are a part of the Charities Department, and are not subject to any supervision by the hospital authorities. Your committee feels that those Social Service workers should be made a part of the general organization of the General Hospital, and be put directly under the executive superintendent of the hospital, and, therefore, recommends:

3. *That the Social Service Division attached to the Hospital be transferred from the Charities to the General Hospital.*

With respect to the number of wasted patient days, it was found that the cause of that condition is chargeable to the lack of supervision over interns, residents, and members of the attending staff. Your committee is informed that, on numerous occasions, a patient's stay is needlessly prolonged because of one of the following reasons:

(*a*) The intern has failed to prepare the patient for examination by the resident physician.

(*b*) The resident physician has failed to prepare the patient for consultation or treatment by the attending man.

(*c*) The attending man, because of his private practice, has been unable to perform a scheduled operation on time, or has failed to examine the patient when prepared.

Other factors which contribute to the waste of patient days are enumerated in the audit report, but the above three items are considered of utmost importance and are, therefore, specifically set forth herein.

REMEDIES SUGGESTED

To remedy the situation and to obviate in the future the waste of money caused by the loss of patient days, two plans have been suggested.

1. To dispense with the attending staff and replace them with full-time, county-paid physicians.

It was thought that by the expenditure of approximately $100,000 a year for salaries of such full-time men, approximately 60,000 patient days could be conserved, in which case, either the appropriation for the hospital could be materially reduced or approximately 9,000 additional patients could be cared for, for the same amount of money now being spent.

PLAN FOR THE LOS ANGELES MEDICAL SCHOOLS

Because, however, of the representations that the standard of medical care would greatly suffer by the introduction of such a revolutionary change, another plan was considered. It was thought advisable to require the two medical schools, which are now using the facilities of the County Hospital for teaching purposes (University of Southern California Medical School, and the College of Medical Evangelists), to assume complete authority for the administration of medical care, thereby bringing all of the attending men under the supervision, and within the jurisdiction, of either of the schools now associated with the hospital. It is felt that this plan would place the administration of medical care on a much more efficient basis.

However, in order to insure the success of such a program, your committee has felt that the two schools should furnish, at their own expense, a personnel sufficient to exercise control over every major department of medicine and surgery. This plan has been discussed formally with the responsible representatives of the medical schools, and your committee has been assured that, insofar as the schools are concerned, the plan is entirely acceptable to them. The plan was likewise submitted to the Board of Supervisors. At a meeting held with the Board on January 9, 1939, which meeting was attended by members of this committee together with Eugene M. Berger and President Percy Magan of the College of Medical Evangelists, Deans McKibben and McPherson of the two medical schools, a member of the Board of Trustees of the University of Southern California, Doctor Raulston, Chief of the Medical Service of the County Hospital, and Col. Wayne Allen, County Manager, the Board of Supervisors, we are pleased to report, unanimously expressed themselves in favor of the plan as submitted by your committee, and have assured us that they will take the necessary action to bring the plan into operation immediately.

In the opinion of your committee, the plan, if adopted, will materially improve conditions at the General Hospital; it will eliminate the waste of patient days; and it will bring under central responsible authority all of the elements involved in the administration of care; and your committee, therefore, respectfully recommends:

2. That in consideration of allowing the local medical schools the continued use of the County Hospital facilities for teaching purposes, the medical schools be required to assume the responsibility for the control of the medical functions, and that the medical schools, in order to meet their responsibility, provide at their own expense a supervisorial staff suitable for that purpose.

SURVEY OF THE ALAMEDA COUNTY HOSPITAL INSTITUTIONS COMMISSION PLAN

In addition to the study of conditions at the General Hospital, which the committee has made its major assignment during the year 1938, your committee has studied the administration of like institutions in Alameda and San Francisco counties. The plan followed in Alameda County in administering its functions with relation to the hospital is one that received particular study from us. It was found that in Alameda County the Board of Supervisors had created an Institutions Commission which administers all of the county health institutions. To quote:

"Briefly, the Alameda County Plan is now coördinating the Alameda County's Charity program as it relates to hospitalization and the care of indigent sick, and also exercises some degree of supervision over the volunteer agencies that have become associated with the Commission for the purpose of forming a unified program dealing with medical and preventive care of all persons living in Alameda County. It is reported that, under the Alameda County Plan, indigents requiring care, whether at the home of the indigent, by way of out-patient relief, or in a hospital in the county, is supplied at the expense of the county.

"As to that class of persons falling in the bracket of the so-called middle class, which are those able to pay some part of the expense, the organized medical profession, through the Alameda County Medical Association, has agreed to take care of such patients on a part-pay basis, usually less than normal fees. It is reported that this part-pay program has been operating for several years, and was organized by mutual agreement between the Alameda County Medical Association and the Alameda County Institutions Commission. Such so-called middle-class patients who are unable to pay full fees, but who are not eligible for county care because of failure to meet the legal requirements as indigents, are referred to members of the County Medical Association in rotation for such care as the patients may require.

"The Alameda County Institutions Commission, in the administration of its various functions, provides free medical care for persons who meet the following requirements:

"1. Legal residence of Alameda County and State of California.

"2. Who require care in clinics, hospitals, sanitariums or preventoriums.

"3. Who are unable to pay for such care at minimum rates without depriving themselves or their families of the basic necessities of life.

"4. Whose responsible relatives are likewise unable to provide such care.

In the main, the Alameda County Institutions Commission renders free care only to persons who meet the statutory requirements as laid down by State law and county ordinance, which requirements are in all essentials similar to those of Los Angeles County.

"The Institutions Commission of Alameda County functions through a medical director and administers:

"1. The Highland Hospital for acute general patients, its emergency department together with its psychopathic ward.

"2. The Fairmont Hospital for chronic patients, including tuberculosis patients of all types, and indigent patients.

"3. The Arroya Sanatorium for tuberculosis patients.

"4. The Del Valle Preventorium.

"5. Clinics at Berkeley, Oakland, Alameda, San Leandro, and Hayward.

"The Medical Social Service, such as is administered in Los Angeles County by the Superintendent of Charities, covering both in-patients and out-patients, is administered in Alameda County directly under the Institutions Commission, through its medical director. Originally, there was a separation of functions between the medical part of the organization and the general executive part of the organization in Alameda County; but now those two functions are consolidated, and both are administered by one man—the Medical Director—who is superintendent as well.

PRESENT LOS ANGELES COUNTY ORGANIZATION

"The situation in Los Angeles County is, briefly, as follows:

"The General Hospital is administered by two persons: one a medical man responsible for the professional standards, and the other a business man responsible for the business part of the institution. The Olive View Sanatorium is similarly administered, and the Rancho Los Amigos also has its own separate heads. While all of the institutions are nominally under one central head—the Superintendent of Charities—each one must of necessity steer its own course. It is manifestly impossible for one person acting as Superintendent of Charities to be in close contact with the intimate details of each of the institutions in Los Angeles County, especially when it is realized that our General Hospital alone is probably larger and spends more money than do all of the Alameda County institutions combined.

PROPOSED CHARTER AMENDMENTS

"The Los Angeles County Medical Association, acting through one of its special committees, is now proposing an amendment to the charter of Los Angeles County, by the terms of which amendment the Los Angeles County General Hospital, the Olive View Sanatorium, the Rancho Los Amigos, and the County Cemetery, would be under the exclusive charge of an Institutions Commission. The proposed amendment also provides that the Institutions Commission would have the power to appoint the superintendents and all other personnel, and would have complete charge of the institutions, subject only to the general laws of the State in so far as the same provide for the approval of the County Board of Supervisors. If such an amendment is adopted and incorporated in the laws of the county, the Board of Supervisors would appoint an Institutions Commission, who would in turn take over the complete responsibility for running the institutions above mentioned. The Superintendent of Charities, would, of course, continue to administer, as heretofore, all matters of social service and general charity work, except in so far as the same may relate to cases under the jurisdiction of the Institutions Commission.

ADVANTAGES OF AN INSTITUTIONS COMMISSION

"It is pointed out that the Institutions Commission would be an independent, nonpolitical organization entirely divorced from the Board of Supervisors and subject to no political domination. If appointments to such commission are made from among the citizens of this county who are public-spirited and qualified by experience and training to serve on such commission, unquestionably a great deal of good can be accomplished. The Institutions Commission in Alameda County is made up of business men, physicians, university professors, a dentist, and a police judge; and while we have had no opportunity to inquire into the detailed affairs of the Alameda County Institutions, we are under the impression that the Commission has functioned efficiently throughout the years of its existence.

"Whether or not a similar commission in Los Angeles County will meet with the same degree of success depends, of course, upon the caliber of persons appointed to such commission and the integrity of the personnel through whom such commission will administer its affairs."

* * *

In view of the fact that the proposed charter amendment heretofore mentioned in this report was received by the Board of Supervisors at too late a date for their consideration and to be placed on the November, 1938, ballot, your committee suggested that an Institutions Commission be established by ordinance, which met the approval of the Board.

Your committee feels that if, and when, an ordinance is adopted and the Institutions Commission comes into being, much can then be done to bring the various institutions under one central responsible authority. A central clearing house of information could thus be established, and the transfer of patients from one institution to another, wherever necessary, could be much more expeditiously accomplished. . . .

Respectfully submitted,

Charities and Health Committee.

William W. Nuzum, *Chairman*.

Approved, January 11, 1939.

* * *

Hospital Aid Group Asks Economies

Would Put Issue Up to Board

"Too Complex System" Is Pointed Out

A study of County General Hospital management today was advocated by the hospital advisory committee as a means toward proper and economical management.

The committee includes Dr. Robert A. Millikan, Archibald B. Young and Albert B. Ruddock of Pasadena, and Maynord McFie, Mrs. John D. Fredericks, J. Walker Schneider, Mrs. Helen Van Dyke, John C. Macfarland and Roy E. Noftzger. All joined in the recommendation except Mr. Young, who was absent from the city and could not be reached.

In its communication received by the Board of Supervisors today, the advisory committee declared that the effectiveness and economical operation of the hospital is handicapped by the complexity of relationships between different authorties. The committee also complains of the lack of clarity of its own position.

Specific reference is made to plans of the Board of Supervisors to combine the hospital and charities department managements. Such a move should not be made until the study suggested has been completed. The committee recommended that either it be named to conduct this study or a special committee be appointed to do so.—Pasadena *Star News*, February 18.

ANNUAL REPORT OF THE SURGEON GENERAL, U. S. PUBLIC HEALTH SERVICE, FOR THE FISCAL YEAR 1938: SUMMARY

Surgeon General Thomas Parran in his annual report said: "A greater advance has been made in public health in the United States during the past two years than ever before within a comparable period."

Doctor Parran, reviewing the work of the organization, at the close of the 140th year of its existence, noted developments that have followed the assumption of new responsibilities by the Government in matters relating to public health, particularly with reference to activities made possible through the enactment by Congress of the Social Security Act, the Venereal Disease Control Act and the National Cancer Institute Act.

GENERAL HEALTH CONDITIONS

Commenting upon health conditions in the United States during the fiscal year ended June 30, 1938, the report states that the general death rate for the calendar year 1937 was 10.9 per 1,000 population, as compared with 11.3 for the preceding year. This favorable condition continued in 1938, when preliminary figures for the first six months disclosed a mortality rate of 10.8 per 1,000 population as compared with 11.8 for the corresponding period of 1937.

There was also recorded a decrease in infant mortality from 57.1 per 1,000 live births for 1936 to 54.4 in 1937. The maternal mortality rate continued to decline; 4.6 per 1,000 live births in 1937 against 5.3 during 1936.

As infant, maternal and general death rates are sensitive indexes of prevailing health conditions, the reduced rates in these fields indicate a decidedly favorable trend.

Tuberculosis mortality resumed a downward course after a slight increase in 1936. The improvement was apparent in the provisional tuberculosis death rate which declined from 51.7 per 100,000 population in 1936 to 49.6 in 1937.

During 1937 lowered death rates were reported for typhoid fever, scarlet fever, diphtheria, tuberculosis, malaria, pellagra, nephritis and puerperal causes. With regard to smallpox, Doctor Parran said: "During 1937 a total of 11,673 cases of smallpox was reported, as compared with 7,834 in 1936 and 7,957 in 1935. The number of reported cases in 1937 was the highest since 1931. Fortunately the prevailing smallpox is of a mild, nonvirulent type, causing relatively few deaths. The eradication of this unnecessary disease depends upon the intelligent application of vaccination."

The United States suffered minor epidemics of influenza and poliomyelitis in 1937. The number of cases of poliomyelitis, 9,511, has been exceeded only in four previous years for which records are available, 1916, 1927, 1931 and 1935.

The leading causes of death in 1937 were diseases of the heart, cancer and other malignant tumors, pneumonia, cerebral hemorrhage and softening, nephritis, accidents (except automobile) and tuberculosis.

QUARANTINE AND IMMIGRATION

The magnitude of federal quarantine and immigration activities is indicated by the Public Health Service inspection of ports at entry of 1,784 airplanes carrying 23,172 passengers and inspection of 15,873 vessels carrying 789,591 passengers and 1,196,688 seamen. Fumigation of 1,004 vessels was performed and 5,399 rats were examined for evidence of plague infection. Medical officers at various United States ports of entry inspected 2,447,339 alien passengers and 805,306 alien seamen. Of these, 20,372 passengers and 1,438 seamen were reported as having some certifiable disease or defect. In foreign countries 65,261 applications for immigration visas were examined by Public Health Service officers.

The continued success of so-called radio pratique at New York and Boston made practicable the extension of this time-saving measure to certain vessels entering the ports of San Francisco and Los Angeles.

VENEREAL DISEASE CONTROL

The most important event in the campaign against the venereal diseases during the fiscal year was the enactment by the Congress of the Venereal Disease Control Act, whereby facilities for the more effective control of syphilis and gonorrhea were placed upon a permanent national basis.

During the year the Congress appropriated $3,000,000 for the purpose of assisting States and their political subdivisions in establishing and maintaining adequate measures for the prevention, control and treatment of venereal diseases. There were also included provisions for training of personnel and for making studies, investigations and conducting demonstrations designed to develop more effective control measures.

The use of Social Security funds for the training of physicians in the clinical management and public health control of the venereal diseases was continued in several universities and clinics. A number of State health officers availed themselves of this opportunity to recruit qualified personnel. . . .

The experimental control of syphilis among indigent people of rural areas was demonstrated by the use of a trailer clinic in Georgia. . . .

MENTAL HYGIENE

With the completion of the Public Health Service hospital at Fort Worth, Texas, for the care and treatment of drug addicts the facilities for this specialized work have been materially increased. The hospital at Lexington, Kentucky, engaged in treating drug addicts and making scientific investigations, operated to full capacity with an average daily census of 949 patients.

The Public Health Service continued to supervise and furnish medical, psychiatric, technical and other scientific services to federal and penal institutions. Special studies were conducted in coöperation with the Mental Hygiene Survey Committee to stimulate interest in the adequate care of the mentally ill, to bring about greater equality and wider distribution of facilities, promote uniform policies and improve the facilities for psychiatric instruction.

A feature of the work of this division was the field studies in mental hygiene for determining the basic nature and factors involved in the production of mental disorders encountered in a typical American community.

MARINE HOSPITALS AND RELIEF STATIONS

The twenty-seven hospitals of the Public Health Service, engaged in the care and treatment of legally designated beneficiaries, and also in scientific clinical research, furnished hospital and outpatient relief at 154 ports, where 566,931 accredited persons applied for treatment. This represents an increase of 211,121 patients over the preceding year. Merchant seamen continued to constitute the largest class of beneficiaries.

Research was continued in pyretotherapy, focal infections, arthritis and psoriasis. Vitamin D was shown to be valuable in the treatment of psoriasis.

NATIONAL INSTITUTE OF HEALTH

The erection of a group of specially designed structures for the National Institute of Health on a site near Bethesda, Maryland, makes available increased facilities for scientific research into the causes and prevention of disease. The investigative work of the Institute covers an increasingly broad field. Continued attention was directed to the control of biologic products, particularly antipneumonococcic rabbit serum, antimeningococcic serum, and close supervision over the stability of arsphenamine.

In the field of industrial hygiene investigations were directed to the development of means for the protection and the improvement of the health of workers in various fields of industry among which the pottery, granite, lead storage batteries, fur and manganese industries may be mentioned.

"The activities of the National Institute of Health," comments the Surgeon General, "are becoming increasingly varied and numerous. Thus, one group of workers is engaged in chemical and chemotherapy research while another is directing its attention to studies of such infectious diseases as Rocky Mountain spotted fever, typhus fever, scarlet fever, Weil's disease, leprosy and poliomyelitis. A special series of investigations have shed considerable light upon the various phases of trichinosis infection and the means of its prevention. Clinical, epidemiological and laboratory studies of heart disease, especially the rheumatic type, have produced valuable information."

The interesting discovery was made that flourides, which cause mottled enamel that disfiguring discoloration of the teeth, may be removed from drinking water by treatment with manganese dioxide, a method which gives promise of economical development.

A firm basis for future cancer studies is being laid through grants-in-aid to selected institutions and the training of research specialists. Already a broad field of investigation is receiving attention.

COÖPERATIVE ACTIVITIES

Every state and many cities, as well as every department and independent agency of the Federal Government has received some degree of assistance from the Public Health Service in solving special health problems arising in the course of routine operations. This coöperative work, carried on principally by the Division of States Relations, is one of the most important functions of the Service.

The availability of funds under the provisions of the Social Security Act has made it possible to assist in improving state and local health administration. It is especially noteworthy that whole-time health services in rural areas have been greatly augmented. From January 1, 1935, to December, 1937, there was an increase in full-time health units of 96 per cent. Facilities for the promotion and supervision of such full-time facilities have been developed in nineteen states.

Stimulated by federal grants-in-aid the state and local appropriations for public health purposes have increased $8,000,000 annually.

Coöperation was continued with the states and the Works Progress Administration by providing technical supervision of work relief labor projects for the construction of sanitary toilets, malaria control drainage in the South and sealing of abandoned coal mines. Certification of water supplies used by interstate carriers, a valuable measure in preventing water-borne illness, continued without interruption.

NATIONAL HEALTH PROGRAM

"It is a matter of grave concern," comments Doctor Parran, "that approximately 40,000,000 people in the United States—the lower economic third of our population—are unable to provide themselves with medical care during serious illness. In the country as a whole there is a deficiency of 360,000 hospital beds, including facilities for the care of mental and tuberculous patients."

Fortunately, the National Health Survey, conducted several years ago by the Public Health Service with work relief personnel, has furnished a great deal of reliable, even though astounding, information concerning the kinds of illness prevailing in this "third of the population," the ages of the victims, their approximate economic status, their employability and other facts closely related to their ability to secure adequate medical treatment.

When these data had been studied and tentative conclusions formulated by the President's Interdepartmental Committee on Coördination of Health and Welfare Activities, it was obvious that the Federal Government had a definite responsibility in seeking a remedy for this undesirable state of affairs. It was shown, for instance, that despite the improvement of state and local health services resulting from the application of grant-in-aid provisions under Titles V and VI of the Social Security Act there are large rural areas and many cities in which adequate health service is not yet available. Only a few states have even fairly satisfactory programs for the prevention of mortality from pneumonia and cancer and there still are serious deficiencies in the control of tuberculosis and malaria. Very little is being done by most of the states in the field of mental hygiene, and there is need for a much greater expansion of industrial hygiene activities.

In closing his report Surgeon General Parran recommended among other essentials, the establishment in the National Institute of Health of a unit for wider chemotherapy investigations, additional funds under the Venereal Disease Control Act on an increasing scale until an annual appropriation of $25,000,000 is reached, and the establishment of a neurological institute for laboratory and clinical investigations of mental and nervous diseases.

STATE MEDICAL LEGISLATION

Under the above caption, the *Journal of the American Medical Association* is printing in each number summaries of medical legislation proposed in various states. In the issue of February 25, 1938, the comments given below appeared concerning bills introduced in the California Legislature, now in session. Supplementary to other items in this issue of CALIFORNIA AND WESTERN MEDICINE,* the following informative data may be of interest to members of the California Medical Association. Excerpt follows:

CALIFORNIA

Bills Introduced.—S. 548 proposes so to amend the Insurance Code as to permit the organization of corporations to operate so-called nonprofit health and hospital service plans whereby there may be furnished by those corporations to their subscribers (1) medical care through licensed physicians employed by the corporation, (2) hospitalization, (3) nursing care, (4) dental care, and (5) drugs and medicines.

S. 696 proposes to authorize county boards of education to require school teachers to present certificates from physicians that they have submitted to physical examinations within three years last past and have been found free from tuberculosis.

A. 1018, to amend the State Food and Drug Act, proposes, among other things (1) to re-define the term "drug" so as to include specifically "all chemicals or substances of whatsoever nature in the treatment of obesity due to whatever cause," and (2) to provide that the standard of purity of drugs shall be that of the United State Pharmacopeia and National Formulary and such further standards of strength, quality or purity as the state board of health may make relating to drugs not in the United States Pharmacopeia or in the National Formulary, and the regulations and definitions adopted for the enforcement of the Federal Food and Drugs Act of 1906.

A. 1019 proposes to make the sale, dispensing, administering or prescribing of diphenylamin for any purpose a felony.

A. 1131, A. 1147, and A. 1177 propose to enact a new law to regulate the sale and distribution of drugs, cosmetics, and therapeutic devices.

A. 1147 and A. 1177 propose to regulate also the sale and distribution of food.

A. 1515, to amend the Workmen's Compensation Act, proposes (1) to give an injured employee the right to select a consulting physician, at the expense of the employer, if the employee is dissatisfied with the medical treatment being received from the physicians retained by the employer or insurance carrier; and (2) to provide that no injured workman, shall be required to submit to an examination by an independent expert medical examiner selected by the industrial commission.

S. 517, S. 1208, and S. 1215 propose to enact a so-called "Consumers' Protection Act" to regulate the sale, distribution and advertising of foods, drugs, cosmetics, and health devices.

S. 524 proposes to authorize the Director of Institutions, with the approval of the State Board of Control, to provide an institutional unit or units for the custodial care and treatment of defective or psychopathic delinquents of both sexes.

S. 551 proposes to enact a compulsory health insurance act whose so-called benefits are to be available to all employees in the state and to such other persons as voluntarily elect to come under the act. The benefits are to consist of all forms of medical, dental, hospital and nursing services, cash payments in the event of disability, and certain cash maternity benefits. These benefits are to be paid for from a payroll tax amounting to 6 per cent of wages paid.

S. 1128 and A. 2172 propose to establish a system of compulsory health insurance applicable to all persons now subject to unemployment insurance. The bill proposes to make available to such individual all forms of medical, dental and hospital services which will be paid for by means of an additional payroll tax. The bill also proposes to permit any other person to elect to come under the act if his annual income is not more than $3,000.

A. 1203 proposes to enact an independent naturopathic practice act and to create a so-called "self-sustaining board of naturopathic examiners" to examine and license persons desiring to practice naturopathy.

A. 1505, to amend the Business and Professions Code, proposes that "All advertising of medical business or the actual practicing of any system or mode of treating the

(Continued on Advertising Page 54)

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* See page 172 (editorial comment) and page 213 (list of bills).

CALIFORNIA PHYSICIANS' SERVICE*

Questions and Answers Concerning the Medical Service Plan

The following questions and answers have been edited by the Board of Trustees of the California Physicians' Service; the answers, therefore, constitute the official statements of the California Physicians' Service:

(Note: All of the chapter and section numbers refer to chapter and section of the by-laws which furnish authority for the answer given.)

(Q.) *What is California Physicians' Service?*

(A.) It is a California non-profit corporation formed for the purpose of enabling its beneficiary members to pay their physicians and hospitals for medical and hospital care by means of pooling periodic payments. (Chap. 1, Sec. 1.)

(Q.) *Will anybody make a profit?*

(A.) No one. (Chap. 1, Sec. 1.)

(Q.) *What will the corporation do with the money it receives?*

(A.) A minimum amount of it will be used for administrative costs, hospitalization and the establishment of a reserve against the possible unforeseen risks such as epidemics. The rest of the money will be distributed to the doctors who give the service. (Chap. 1, Sec. 2.)

(Q.) *On what basis will be the doctors be paid?*

(A.) On the unit system. (Chap. 19, Sec. 2.)

(Q.) *What is meant by the unit system?*

(A.) A method of computing the compensation due to the physician who has rendered medical or surgical service whereby a proportional valuation is set upon each kind of service by counting each such service as a determined number of units. (Chap. 19, Sec. 1.)

(Q.) *How will the value of a unit be determined?*

(A.) First, a fee schedule in units will be adopted; each second month the total number of units of medical service furnished by the professional members that month and billed for will be added together; third, the total amount of money received will be computed; fourth, a proportion of this money will be set aside for cost of hospitalization, administration and reserve; fifth, the total amount of money remaining will be divided by the total amount of units and the result will be the monetary value of one unit for that month. (Chap. 19, Sec. 1.)

(Q.) *What would happen if there were not enough money in the fund to pay the unit value?*

(A.) This can't happen because the amount of money on hand, no matter how small, can always be divided by the number of units. This is the reason for the unit system rather than cash indemnity.

(Q.) *What would happen if there were more money than was needed to pay the full schedule established by the Board of Trustees?*

(A.) Such surplus will be handled as a reserve fund by the trustees and when they deem it possible they will distribute it on the unit system to those doctors who have previously received for their services less than the schedule provided as a maximum for the services so rendered. Any surplus beyond that will be used either to reduce rates to the beneficiaries or to extend the services offered them. (Chap. 19, Sec. 4.)

(Q.) *Are there different kinds of members?*

(A.) Yes. There are administrative members, professional members and beneficiary members. (Chap. 2, Sec. 1.)

(Q.) *May a person belong to more than one class of members?*

(A.) If he is otherwise eligible he may belong to all classes of members. (Chap. 2, Sec. 1.)

(Continued on Advertising Page 38)

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* These questions and answers will be printed in a separate brochure, with copy of the by-laws, physician's registration blank, etc. A copy of the pamphlet will be sent to every doctor of medicine licensed in California. The address of the medical service corporation is California Physicians' Service, Mills Building, 220 Montgomery Street, San Francisco. Mr. Allen Widenham, manager. See also, in this issue, on page 210.

TWENTY-FIVE YEARS AGO†

EXCERPTS FROM OUR STATE MEDICAL JOURNAL

Vol. XII, No. 3, March, 1914

From Some Editorial Notes:

What Is the Value of Anything?—A very great objection to the schedule of fees offered by the associated insurance companies for the services of physicians under the new insurance and compensation act, is the fixing of a flat fee. Fees for professional work cannot be absolutely fixed; as a matter of fact, the value of everything is relative, and the old saying of "charging what the traffic will bear" is fundamentally true and right. The freight rate on silk is more per ton than that on pig iron; a lawyer gets a bigger fee for incorporating a fifty-million-dollar concern than a thousand-dollar company; a surgeon is entitled to a larger fee for removing the appendix of a millionaire than for taking out that of a car conductor. Some of our best surgeons have a system of charging that is based upon the income of the individual and represents one or more month's income for the work to be done, and this seems to be a reasonable and equitable way of fixing the fee. It is foolish for anyone to say that it is as much work and strain and responsibility in the case of the poor man as in that of the rich man. Just as much coal is burned in hauling a ton of silk as in pulling a ton of pig iron over a certain distance. Therefore, the contracting to do certain professional work for certain fixed fees, irrespective of the income of the patient, is fundamentally wrong and vicious.

* * *

Squeezing the Companies.—Doctor French read a paper on the subject of industrial compensation insurance, etc., before the Los Angeles County Medical Association and, in the main, took the attitude voiced in your journal in connection therewith. One point he brought up, however, is new in so far as it has not been mentioned in these pages; that is, the fact that some physicians will try to make the bill unduly large if they know that an insurance company of large capital is going to pay out the money. Probably that is, in a few cases, true. Physicians are average men and probably have but a little more than the average rate of honesty; in every walk of life and in every calling we shall find rascals and dishonest men; occasionally one reads of some clergyman who has been detected leading an immoral or a dissolute life, but because of that we do not condemn all clergy nor do we think of them as all being dissolute. Every practicing physician does a great deal of work for nothing, and the very nature of his calling leads him to try to think more honestly than does the daily occupation of the average man in any other calling; therefore, we truly believe that physicians are to some extent more honest in the average than those in other walks of life. But even at that there will be some cases of attempted grafting, no matter what is done. The plan presented in this issue and strongly recommended to county medical societies for their consideration, will, we think, do away with the charge of possible graft. Still, it seems to be a peculiar phase of human nature that everyone must try to get "something for nothing," particularly when it is a corporation that is to be depleted. People who would never put a hand in an individual pocket will avoid paying car fare if they can, and we all know the predatory instinct that removes things from hotels! Doubtless many physicians who would be perfectly honest with an individual patient would not think it wrong to try to "stick" a corporation. It is a queer people!

* * *

Important Business.—Not in the past twenty years have so many questions of vital importance to the medical profession and to the members of our society presented themselves as at the present time. They will come up for discussion and for action at the annual meeting next month,

(Continued in Front Advertising Section, Page 20)

BOARD OF MEDICAL EXAMINERS OF THE STATE OF CALIFORNIA†

By Charles B. Pinkham, M.D.
Secretary-Treasurer

Board Proceedings

At a regular meeting of the Board of Medical Examiners held February 6 to 9, 1939, in Independent Foresters' Hall, 1329 South Hope Street, Los Angeles, the following changes were made in the status of various licentiates:

LICENSES RESTORED

Mahlon C. Cooley, M.D., license revoked on June 30, 1938, following his conviction of asserted ambulance chasing and insurance frauds; restored on February 9, 1939, and placed on probation for a period of five years on condition that he obey all laws and report at the Los Angeles meeting each year.

Anton Lopez del Castillio, M.D., license revoked on March 1, 1934, for alleged abortion; restored on February 6, 1939, and placed on probation for five years; to report at each Los Angeles meeting.

Paul F. Eid, M.D., license revoked on March 10, 1938, on record of conviction which was set aside by San Mateo Superior Judge Cotton; restored on February 6, 1939, because of setting aside of record of conviction.

W. Burlin Humphrey, M.D., license revoked on June 30, 1938, on record of conviction of so-called ambulance chasing and insurance fraud; restored on February 9, 1939, and placed on probation for five years; to report at each Los Angeles meeting.

Louis Kameny, M.D., license revoked on June 30, 1938, on record of conviction of so-called insurance fraud; restored on February 7, 1939, and placed on probation for five years; to report at each San Francisco meeting.

Samuel Calvin Long, M.D., license revoked on July 1, 1937, for alleged abortion; restored on February 6, 1939, and placed on probation for five years; to report at each Los Angeles meeting.

William Raymond McDannell, M.D., license revoked on October 27, 1938, for failure to comply with terms of stipulation. Reopened on February 6, 1939. To be restored on filing, within seven days, a stipulation limiting the character of his advertising. Stipulation filed February 8, 1938.

Guy O. McKeehan, M.D., license revoked on June 30, 1938, based on record of conviction of so-called ambulance chasing and insurance fraud; restored on February 9, 1939; placed on probation for five years; to report at each Los Angeles meeting.

William F. Meyer, M.D., license revoked on October 19, 1937, based upon adjudication of insanity; restored on February 6, 1939, based on certification of restoration to competency.

Alfred H. Valentine St. John M.D., license revoked on February 10, 1937, on record of conviction in connection with so-called Pacific Coast Abortion Ring; restored on February 6, 1939, based upon the setting aside of record of conviction and granting of new trial.

Arthur M. Tweedie, M.D., license revoked on June 30, 1937, for violation of probation; restored on February 6, 1939, and placed on probation for five years without narcotic privileges; to report at each Los Angeles meeting.

PENALTIES IMPOSED FOLLOWING HEARINGS

Boyajian B. Armen, M.D., license revoked on February 8, 1939, based on narcotic conviction.

Winfield L. Bartow, M. D., was on February 8, 1939, found guilty of use of fictitious name. Placed on probation for five years.

Arthur Bowen, M. D., was on February 8, 1939 found guilty of prescribing for a known addict. Placed on probation for three years without narcotic privileges or possession. To report at each Los Angeles meeting.

Harry W. Boyd, M.D., charged with (1) aiding and abetting, (2) use of fictitious name, both in connection with the so-called Samaritan Treatment for Alcoholism, Los Angeles Branch. Found guilty on February 8, 1939,

(Continued in Front Advertising Section, Page 28)

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† This column strives to mirror the work and aims of colleagues who bore the brunt of Association activities some twenty-five years ago. It is hoped that such presentation will be of interest to both old and new members.

† The office addresses of the California State Board of Medical Examiners are printed in the roster on advertising page 6.

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Baxter's Dextrose and Saline Solutions are tested and inspected, guarded, by a rigid *system* of laboratory controls . . . as exacting and as certain as we can devise.

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In Vacoliters, Baxter's Intravenous Solutions are protected by our exclusive tamper-proof seal that shuts out contamination . . . that keeps Baxter's *tested laboratory purity* intact . . . ready when you need it.

DON BAXTER, Inc.
Research and Production Laboratories
GLENDALE, CALIFORNIA

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Shaw Supply Co.	*Tacoma-Seattle*
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A Limited General Hospital of 200 Beds

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Limited General Hospital with accommodations for 220 patients located in a seven-acre park. Fourteenth and Noe Streets, San Francisco.

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President

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Chief of Staff

FRANK SCHMIDT
Superintendent

BOARD OF MEDICAL EXAMINERS

(Continued from Page 31)

ful of sod and deposited it in a golden bucket held by Dr. Howard M. Engle. Through the services of Doctor Engle, the late Mrs. Viola Dunn bequeathed $100,000 to the hospital rebuilding fund, Dr. Ward announced. The old hospital was razed in 1930. Marshal Hale, who presided over the ground breaking ceremony, acknowledged other large bequests made by the late E. D. Tenny, Mrs. John H. Miller, P. C. Hale and John B. Blair. 'This splendid hospital—with its excellent facilities and free clinic—has been very much needed in the city's hospital system,' said Dr. J. C. Geiger, public health director. Other speakers included John L. McNab, Miss Alice Boldemann and Mrs. Juliette Bartel. (San Francisco *Examiner,* February 2, 1939.)

"Attorney-General Earl Warren announced today that he will leave for Washington this week to aid the California congressional delegation in its fight against the resolution of Senator Gerald P. Nye, under which the federal government would take steps to acquire California's invaluable oil bearing tidelands. . . . The attorney general said he was here to attend a 'routine' meeting of the State Board of Medical Examiners and to confer with members of his staff here. . . ." (Los Angeles *Herald and Express,* February 6, 1939.)

"Charged with the illegal operation death of Mrs. Bertha May Murray, Oakland housewife, last December, Mrs. Lena Mareck, 819 Ocean Avenue, was held for a Superior Court trial by Municipal Judge Kaufman at a preliminary hearing yesterday. Mrs. Mareck pleaded not guilty. Bail was fixed at $10,000 cash or $20,000 bond. Following this, Attorney Nathan Coghlan filed a petition for her release on a writ of habeas corpus, contending no crime had been proven against her. A hearing on the petition was set for February 10." (San Francisco *Chronicle,* February 4, 1939.) (Previous entries February, 1927; November, 1934.)

"Congressional action to bring medical advertising by radio under control of the Federal Communications Commission was urged yesterday by the North End Improvement Association. A resolution sent to the California delegation in Congress, declared that 'the constant, promiscuous advertising of drugs over the radio is a source of injury to the general public,' that 'many statements as to the virtues claimed for the drugs are false and misleading,' and that 'the patient is encouraged to make his own diagnosis, which may be completely in error.' The association urged that the commission be instructed to investigate all claims and recommendations made by radio concerning the action of drugs." (San Francisco *Examiner,* January 28, 1939.)

"An impending shortage of officers in the Navy Medical Corps will require the appointment of seventy-five officers annually for the next five years, according to a Navy Department report received here today." (San Diego *Sun,* January 24, 1939.)

"Articles of incorporation and by-laws of the California Physicians' Service, sponsored by the California Medical Association, are getting their final examination this week at the office of the association's counsel. Hartley Peart, association attorney, said it was hoped to obtain the necessary signatures of doctors from Sacramento to San Diego and file the articles of incorporation by Saturday. Dr. T. Henshaw Kelly, trustee of the new service, said the health insurance plan might be put in operation in the San Francisco and Los Angeles areas in less than three months. Headquarters will be here. The association council, meeting here Saturday, loaned the corporation—which will operate autonomously and independently of the associa-

(Continued on Page 36)

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BOARD OF MEDICAL EXAMINERS

(Continued from Page 34)

tion—$15,000. Trustees named were Drs. Ray Lyman Wilbur, Lowell T. Goin, T. Henshaw Kelly, C. Kelly Canelo, W. Earl Mitchell, Samuel Ayers and Alson Kilgore. . . . Employed groups in certain income brackets—still to be determined—will be the first eligible to the medical and hospital service upon payment of a flat monthly fee. Later it is planned to open membership to individuals, including indigents. . . ." (San Francisco *News,* January 16, 1939.)

"Robert A. Gilbert, stage hypnotist, who won an appeal from conviction of conspiracy to perform an illegal operation, recently walked from the county jail a free man. Superior Judge A. A. Scott, in whose court Gilbert was convicted by a jury last September 16, signed an order for his release. Gilbert was sentenced to two to five years and has awaited outcome of his appeal in the county jail ever since. The district court of appeal reversed the conviction, declaring no evidence of any crime was given at the trial indicating any effort had been made to bring about an abortion." (Los Angeles *Daily News,* January 18, 1939.)

"Dr. Roy G. Labachotte, nationally known Redwood City chiropractor, has been notified of his appointment to the State Board of Chiropractic Examiners. . . . Dr. Labachotte succeeds Raymond C. Foy. . . ." (Half Moon Bay *Review,* January 5, 1999.)

". . . Some years back, the writer sponsored the rather famous law directed against the 'diploma mill' which was grinding out diplomas in medicine, law and most everything else at a modest sum, to all takers. The enactment put a check to the easy diploma getting. Yesterday a widely known physician told the writer that even today it is necessary to be on the alert to prevent further outbreaks of the 'diploma mill,' particularly in Los Angeles. . . ." (Editorial by Senator Herbert W. Slater, printed Santa Rosa *Press Democrat,* January 14, 1939.)

"Dr. Melville Z. Ellis, Long Beach, has been named as president of the State Board of Chiropractic Examiners. . . . Dr. Selma Giese, Los Angeles, was named vice-president by the board here yesterday, and R. Joseph Stacy, Sacramento, was made secretary." (Associated Press Dispatch, dated San Francisco, January 11, printed Pasadena *Star News,* January 11, 1939.)

"Two variations of old 'rackets' were reported today by the Better Business Bureau to be operating in San Francisco. Girls representing themselves to be student nurses of St. Joseph's Hospital have been soliciting for a magazine in doctors' offices, Sister M. Bebe of the hospital's school of nursing told the bureau. She declared no such soliciting has been authorized. The bureau reported office workers who purchased pens represented by a glib salesman to be a $7.50 value for $1.00 have later found that they could be purchased in 5 and 10 cent stores for 29 cents." (San Francisco *Call-Bulletin,* January 23, 1939.)

" 'Group medicine,' as conducted by the Pacific Health Corporation, constitutes a violation of the California State Medical Practice Act, the United States Supreme Court ruled in effect yesterday. The nation's highest tribunal refused to pass upon an appeal brought by the corporation from a decision handed down originally by Judge C. J. Goodell in 1934, and subsequently upheld by the State Supreme Court. Judge Goodell ordered the corporation to desist from the practice of medicine. The State Supreme Court had held that the corporation, by selecting and paying licensed physicians to care for members, was in reality

(Continued on Page 38)

RECENT ADVANCES IN THE SCIENCE OF NUTRITION

VII. The Unknown Vitamins

● The past twenty years of biochemical research have steadily brought additions to the list of vitamin factors known to be indispensable in proper human nutrition. Today, only vitamins A, B_1, C and D, riboflavin and the P-P factor are universally considered as essential to man. In general, the requirement for these factors is greater in certain phases of the human life cycle than in others.

This list of essential factors is probably incomplete. It has been aptly stated (1) that our species has evolved in the direction of lengthening rather than shortening the list of known dietary essentials. However, it is reasonable to believe that the above list, although incomplete, probably does include all factors whose absence from the ration may cause the most severe types of human dietary deficiency disease.

Investigations on the nutritive requirements and the biochemistry of the lower forms of animal and plant life constitute the frontiers of modern vitamin research. From studies such as these may come the first clues as to new vitamins which may ultimately be proven essential in human nutrition. For example, it was upon research of this type that the dietary requirement of the rat for riboflavin was established and the importance of riboflavin (1) in human nutrition postulated.

During recent years, a large number of factors essential to animals other than man has been enunciated (2). As examples might be mentioned the factor in plant juices required by herbivora (3); the factor in fresh meat essential to trout (4); and vitamin K, needed for normal blood coagulation in fowls (5). Whether these or others of the factors essential to lower forms of life will also prove indispensable to man, the future must decide.

The knowledge that our present list of essential vitamins may be incomplete, need not be alarming. However, such knowledge should serve to emphasize the desirability of a diet formulated according to the best present concepts of the science of nutrition. Nature intends that man should receive all dietary essentials, known or unknown, through food and it will be through the medium of a judiciously chosen, varied diet that these essentials can best be obtained. Needless to state, the several hundred varieties of wholesome, nutritious, commercially canned foods lend themselves admirably to formulation of such varied, protective diets.

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(1) 1938. J. Amer. Med. Assn. 110, 1278.
(2) 1938. Ibid. 110, 1441.
(3) 1936. Proc. Soc. Exper. Biol. Med. 35, 217.
(4) 1928. Science. 67, 249.
(5)a. 1935. Nature. 135, 652.
b. 1935. Biochem. J. 29, 1273.

We want to make this series valuable to you, so we ask your help. Will you tell us on a post card addressed to the American Can Company, New York, N. Y., what phases of canned foods knowledge are of greatest interest to you? Your suggestions will determine the subject matter of future articles. This is the forty-sixth in a series, which summarize, for your convenience, the conclusions about canned foods reached by authorities in nutritional research.

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BOARD OF MEDICAL EXAMINERS

(Continued from Page 36)

practicing medicine in violation of the State law. . . . It was generally believed that the decision will have no bearing upon the 'group medicine' plan now being organized by the State Medical Association. Attorneys for the association formulated that plan in the light of the State Supreme Court decision in the Pacific Health case." (San Francisco *Examiner,* January 31, 1939.) (Decision printed in California and Western Medicine, November, 1935, page 392.)

"Released by Attorney General Warren yesterday were circulation title and summary for a proposed initiative measure embracing a thorough-going plan for socialized medicine. The proposal would create a Public Health Commission of nine laymen, would vest in the commission authority to establish and maintain hospitals, provide adequate and uniform hospitalization for all California residents. Subject to public service employment by the commission would be all physicians, surgeons, pharmacists, dentists, optometrists, osteopaths, chiropractors, embalmers, funeral directors and registered nurses." (San Francisco *Chronicle,* January 31, 1939.)

"A ruling of Attorney General Earl Warren yesterday limited the right of private institutions or unlicensed persons to render medical services through the medium of a hired physician and surgeon. In a letter to Charles B. Pinkham, secretary-treasurer of the Board of Medical Examiners, the Attorney General held that a licensed physician cannot render medical services to patients of unlicensed persons in consideration of a salary paid to him for performing such services. In addition, the ruling held that a private institution cannot represent itself as rendering medical services and hire physicians to render such services. Pinkham's request for the ruling cited the case in the first instance of two unlicensed persons operating a sanitorium and employing a licensed medical man as medical director." (San Francisco *Examiner,* February 11, 1939.)

"A complaint for declaratory judgment was filed here by Percy Purviance of Richmond against Charles Brockman, Jackson chiropractor, Monday in Superior Court. Purviance claims Brockman refused to comply with terms of a contract made by the two men on November 1, 1938. Purviance, also a chiropractor, according to the complaint, entered into a contract with Brockman whereby Purviance was to work for Brockman and receive 40 per cent of money taken in for treating patients. Purviance is acting as his own attorney." (Press dispatch from Jackson office, Stockton *Record,* dated February 8, printed Stockton *Record,* same date.) (Previous entries, August, September, November, December, 1925; January, February, June, July, September, October, 1926; February, 1927; March, April, July, 1928; January, October, 1929; May, June, 1931; June, 1932; May, June, November, 1934; April, August, September, November, 1935.)

CALIFORNIA PHYSICIANS' SERVICE

(Continued from Text Page 247)

(Q.) *What is an administrative member and how is he chosen?*

(A.) An administrative member must be (1) an active member of the California Medical Association and elected to administrative membership by a plurality vote of those professional members who are represented within the administrative district in which he resides, at an election for such purpose held pursuant to these by-laws, or (2) a person recommended in writing for administrative membership by the affirmative vote, or written assent of not less than two-thirds of all the then administrative members. (Chap. 2, a.)

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(Q.) *What are the duties and rights of administrative members?*

(A.) They hold the voting rights; they elect the trustees; they elect the other administrative members. They adopt, amend or repeal by-laws and they have the right to refer any matter or question of policy to the professional members or to the beneficiary members or both for advisory vote. (Chap. 32, Sec. 1.)

(Q.) *What is a professional member?*

(A.) A legally licensed doctor of medicine who makes application to become a professional member. (Chap. 2, Sec. 6.)

(Q.) *Does he need to be a member of the County Medical Association?*

(A.) No.

(Q.) *Does he pay to join?*

(A.) Yes; $5.00 by resolution of the House of Delegates.

(Q.) *Can he hold office?*

(A.) Yes.

(Q.) *Can he be assessed?*

(A.) Only by majority vote of the professional members (the doctors). The professional members themselves must authorize the assessment. (Chap. 18, Sec. 2.) It may be noted that there is nothing unfair in permitting the doctor to levy an assessment on himself and it is to be noted that it cannot be done without his consent.

(Q.) *Are there any other rules and regulations regarding a doctor becoming a professional member?*

(A.) Yes. He must carry malpractice insurance satisfactory to the trustees. He must abide by the rules and regulations adopted from time to time by the trustees.

(Q.) *Who is a beneficiary member?*

(A.) Any person whose annual income is less than an amount to be determined, and certainly not more than $3,000 per annum, who wishes to obtain the benefits of this organization and who fulfills such requirements as may be imposed. (Chap. 2, Sec. 5.)

(Q.) *What might such requirements be?*

(A.) In the beginning they will, no doubt, be members of any group selected to provide adequate spread of risk, desirous of obtaining medical service.

(Q.) *Will individuals be taken in?*

(A.) Yes, as soon as possible, but experience must be developed and safeguards set up to insure the organization that those who will apply are not solely those who are sick.

(Q.) *How about voluntary groups?*

(A.) The same answer will apply.

(Q.) *Will the state be administered as a whole or by districts?*

(A.) The administration will be decentralized as far as possible into districts.

(Q.) *How many districts?*

(A.) Not less than ten nor more than thirty. (Chap. 2, Sec. 6.)

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(Q.) *Won't those in official positions be likely to direct patients to their friends?*

(A.) No. This will not be tolerated.

(Q.) *How will the patient get a physician?*

(A.) Just as he does now.

(Q.) *How will the physician get his patient?*

(A.) Just as he does now.

(Q.) *Do you mean that there will be no change in the way we practice medicine?*

(A.) There will be almost no change. The change will be in the method by which the doctor is paid and to prevent raids upon the pooled funds there will necessarily be a minimum of supervision. This supervision will be discussed a little later.

(Continued on Next Page)

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CALIFORNIA PHYSICIANS' SERVICE

(Continued from Preceding Page)

(Q.) *Is hospital care under this plan limited?*

(A.) Yes. Hospitalization will be limited to the terms of the hospital contract held by the beneficiary member. (Rules and Regulations.)

(Q.) *Will the amount of money to be spent on hospitalization be limited?*

(A.) Yes, to a definite sum per month, out of the total subscriptions paid by the beneficiary members.

(Q.) *Will medical care be limited?*

(A.) Very slightly.

(Q.) *What limitations are there?*

(A.) Excluded is the treatment of insanity, chronic alcoholism, drug addiction, injuries or diseases incurred while committing lawless acts (since these are matters for the police anyway) and injuries coming under the scope of the Workmen's Compensation Act (since these are otherwise cared for).

(Q.) *Will we take care of sanitarium patients with tuberculosis?*

(A.) No, their sanitarium care will not be provided.

(Q.) *Will we take care of obstetrical cases?*

(A.) It is contemplated we shall under suitable rules and regulations.

(Q.) *Will consultation be allowed?*

(A.) Yes.

(Q.) *Who will choose the consultant?*

(A.) The physician and the patient.

(Q.) *Won't he be chosen by the medical director?*

(A.) No.

(Q.) *What do you mean by medical director?*

(A.) A doctor of medicine employed to supervise the medical details of this plan. The medical director at present is Dr. Morton R. Gibbons, Sr., of San Francisco.

(Q.) *What are his powers?*

(A.) They are rather absolute, but he is expected to use them in great moderation. He will not concern himself with the details of your treatment nor the type of operation you wish to perform except that it will be his duty to assure himself that unscrupulous physicians or patients are not taking advantage of the organization by raiding its funds. His powers will be exercised largely by his assistants in the districts.

(Q.) *Do you mean he will tell me how many calls I can make on a patient?*

(A.) No. Not within any reasonable limits. But if it should be shown that an average broken leg requires medical care for six weeks in the hands of ninety-nine percent of the physicians serving under this plan while one percent insist on attending patients with broken legs for fifteen weeks the medical director would need to assure himself that there is some reason for this before authorizing payment for the additional visits.

(Q.) *Do I have to get his consent before I operate?*

(A.) Yes.

(Q.) *What will I do if it is an emergency?*

(A.) You will use your best judgment?

(Q.) *How will you know whether my patient should have an appendectomy?*

(A.) The medical director or his district assistant will be inclined to trust you until he has reason to do otherwise, but when and if he wishes to he may have your patient examined by an advisor appointed by himself from a list provided by the board of trustees.

(Q.) *Is the same thing true in medical treatment?*

(A.) Yes, but remember that this plan is to be administered by physicians who are practicing medicine the same as you are. They have the same problems that you have

(Continued on Page 42)

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CALIFORNIA PHYSICIANS' SERVICE

(Continued from Page 40)

and there is no reason to assume that they will assume or even wish to assume any autocratic power over you.

(Q.) *Will there be lots of unnecessary calls?*

(A.) Probably. You don't need to accept them if you don't want to.

(Q.) *You mean I don't have to take a case under this plan if I don't want to?*

(A.) Certainly not. You don't have to now, nor will you under this plan.

(Q.) *Suppose the patient doesn't like his doctor?*

(A.) He will do just as he has always done. Discharge him.

(Q.) *Will our offices be crammed with patients who are beneficiary members to this plan?*

(A.) We hope so since that will mean that the people are getting the care they need and the doctor is prospering.

(Q.) *What will we do with the neurotics?*

(A.) Put up with them. Remember that the trustees can drop a person from the plan if satisfied that he has abused his privileges as a beneficiary member.

(Q.) *How will you control the "chiseler"?*

(A.) In the first place, there probably won't be very many. Generally speaking, physicians have a rather high average of integrity and honor, and we will have to deal only with the few who constitute the exception. It is these few that compel us to have some supervision, and for these there will be disciplinary measures provided which can be made adequate.

(Q.) *Can the various types of members, including the beneficiary members, be dropped from the plan?*

(A.) Yes. (Chap. 3, Sec. 1.)

(Continued on Page 44)

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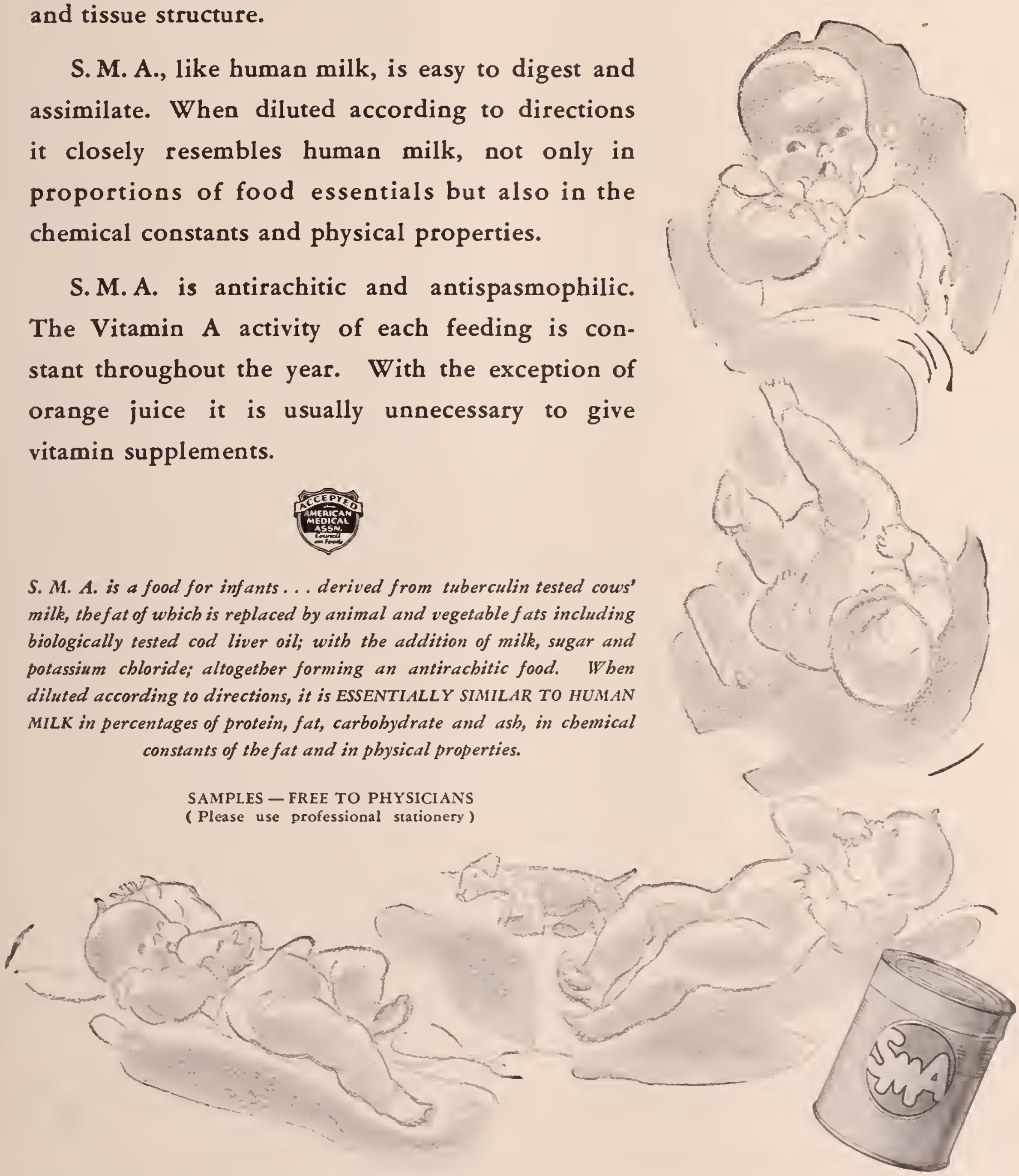

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CALIFORNIA PHYSICIANS' SERVICE

(Continued from Page 42)

(Q.) *How will you get rid of an administrative member who is found not to be useful?*

(A.) He can be expelled for cause from administrative membership by two-thirds majority of the Board of Trustees. (Chap. 3, Sec. 2.)

(Q.) *Can a professional member be expelled or suspended?*

(A.) Yes, under the following conditions: he must be notified of the charges against him ten days before the meeting of the trustees at which action will be taken; he must have a full opportunity to be heard at that meeting; and it requires two-thirds majority of the trustees to expel a professional member. (Chap. 3, Sec. 3.)

(Q.) *Can a beneficiary member be dropped?*

(A.) Yes, by two- thirds majority vote of the trustees. (Chap. 3, Sec. 4.)

(Q.) *Will the administrative members meet?*

(A.) Yes. There will be an annual meeting in March of each year except the year 1939, in which year the first meeting will occur on October 14; thereafter the annual meeting will occur in March. Also special meetings of the administrative members may be called by the president; by the board of trustees; or by any ten administrative members. (Chap. 5, Sec. 2.)

(Q.) *Will there be meetings of the professional members?*

(A.) Yes, they may be called by resolution of the board of trustees; by two-thirds of the administrative members or by any two hundred fifty professional members. District meetings of professional members may be held at stated intervals to elect administrative members or those administrative members may be elected by mail vote.

(Q.) *When are the trustees elected?*

(A.) At the annual meeting of the administrative members. (Chap. 5, Sec. 12.)

(Q.) *To what term is a trustee elected?*

(A.) Three years. (Chap. 7, Sec. 1.)

(Q.) *Could a trustee be removed from office?*

(A.) Yes, by vote of three-fourths of the administrative members. (Chap. 7, Sec. 2.)

(Q.) *What are the powers of the trustees?*

(A.) To control and manage the property and conduct the affairs of California Physicians' Service. (Chap. 7, Sec. 3.) These powers include the power: to adopt a fee schedule or schedules; to make rules and regulations necessary in relationship to the rendition of medical and surgical service and hospital care; to establish a unit system; to engage agents, representatives and employees; to fix dues which may be in different amounts for different classes of beneficiary members; to make contracts; and in general to carry out the purposes of this organization. (Chap. 7, Sec. 3.)

(Q.) *Will there be any financial responsibility upon any member, administrative, professional or beneficiary, for any debts or liabilities for California Physicians' Service?*

(A.) No.

(Q.) *Do the trustees receive a salary?*

(A.) No; they may, however, allow themselves a fee for attendance at board meetings and their actual traveling expenses (Chap. 7, Sec. 4). It may be noted that the trustees feel that they will not accept any fees until such a time as the organization is on a sound footing.

(Q.) *Must the officers of the organization be trustees?*

(A.) No, they may be but they need not be. (Chap. 9, Sec. 3.)

(Q.) *Who appoints the medical director?*

(A.) The trustees. (Chap. 9, Sec. 3.)

(Q.) *Is his appointment for a definite term?*

(A.) No, the length of his service depends on the trustees.

(Q.) *Who may be medical director?*

(A.) A doctor of medicine holding a valid and unrevoked physicians and surgeons' certificate issued to him by the Board of Medical Examiners of the State of California. (Chap. 14, Sec. 1.)

(Q.) *Will there be more than one medical director?*

(A.) No, but there will be at least one assistant medical director in each district who must have the same qualifications as the medical director.

(Q.) *What are the duties of the medical director?*

(A.) To supervise the rendition of medical and surgical and hospital care to beneficiary members. As an executive

(Continued on Page 46)

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CALIFORNIA PHYSICIANS' SERVICE

(Continued from Page 44)

officer of the organization he will also administer and enforce the rules and regulations, and all acts, resolutions, proceedings and orders of the trustees relating to the administration of the medical service.

(Q.) *Do beneficiary members have any representation in this plan?*

(A.) Yes. Chapter 16, Section 1, provides for a board of advisory governors to be selected from the professional and beneficiary members, and the function of this board is to advise the trustees on question of policy.

(Q.) *Why do the rules and regulations require a professional member to carry malpractice insurance?*

(A.) Because (1) otherwise the funds of California Physicians' Service, from which doctors are to be paid, would be in jeopardy in the event of claimed malpractice on the part of a professional member; and (2) any physician who does not carry adequate malpractice insurance is not properly protecting his own welfare.

The following are questions which were circulated in mimeograph form at some of the County Medical Society meetings at which this plan was discussed.

(Q.) *What precautions have been taken to prevent the patient from abusing the plan until the value of a unit drops below the minimum amount upon which the doctor can make a living, pay his expenses and render decent service?*

(A.) Precautions will have to be taken when the need arises for them. The people can be taught that this plan is for their benefit and it is to their benefit not to abuse it. People in general are pretty fair-minded. The average person does not particularly enjoy going to a doctor, and there is no particular reason to believe that any considerable number of them will do so purely for pleasure.

(Q.) *Will the officials involved in this plan be paid on a unit basis, or will their salaries be guaranteed along with all other expenses before the doctor who is rendering the medical service gets paid?*

(A.) The trustees must have the right to pay all employees on a monetary basis. The present medical director, Dr. Morton R. Gibbons, Sr., has agreed to accept compensation on a unit basis.

(Q.) *What definite provisions have been made in the basic plan to guarantee the continuous free choice of the physican by the patient?*

(A.) Every provision that could be thought of has been made and there is nothing in the entire plan that will prevent a free choice of physician. The right of the beneficiary member to select his own physician from among the professional members cannot be denied.

(Q.) *What will prevent any employee of this plan from using his influence to direct patients to certain favored doctors?*

(A.) This question should be answered in three parts: first, the employee will not have any influence; second, the employees will not have any contact with any group of patients except their own relatives and friends; third, it will be impossible to prevent an employee from recommending a physician just as any employee of any company now recommends a physician of his liking to his acquaintances and friends.

(Q.) *What prevents the employer of any group of beneficiaries from directing his employees to any certain doctors?*

(A.) Nothing really prevents it except that the employer has no control over the destiny of his employee and could only advise in any case. It is to be noted that nothing now prevents an employer from directing a group of his em-

(Continued on Page 50)

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1. **Q.** What is the composition of Karo Syrup?

A.

Dextrin	*50.0%*
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Sucrose	*6.0%*
Invert sugar	*4.0%*
Minerals	*0.8%*

(Dry Basis)

2. **Q.** What are the Karo equivalents?

A.

1 oz. vol.	*40 grams* *120 cals.*
1 oz. wt.	*28 grams* *90 cals.*
1 teaspoon	*15 cals.*
1 tablespoon	*60 cals.*

3. **Q.** What is the difference in caloric value between Karo and dry maltose-dextrins products?

A. *Karo Syrup furnishes twice as many calories as similar dry sugars.*

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VITAMIN D REQUIREMENTS

Journal of the American Medical Association, August 20th, 1938, Vol. 111: 703

> "... Tentatively the vitamin D requirement of the infant fed cow's milk may be stated as between 300 and 400 units daily, these amounts having been shown to be efficient in prophylaxis of rickets, in producing ample retention of calcium and phosphorus and in permitting excellent skeletal growth and dentition. This requirement is stated in terms of vitamin D of no greater concentration than is found in average high grade cod liver oil."
>
> "... 300 to 400 units daily as cod liver oil or as milk containing 400 units to the quart allows sufficient vitamin D to prevent rickets of clinical significance in both full term and prematurely born infants."

The above excerpts were taken from the article entitled, "The Human Requirement of Vitamin D," by Doctors P. C. Jeans and Genevieve Stearns of Iowa City.

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CALIFORNIA PHYSICIANS' SERVICE

(Continued from Page 46)

ployees to a particular physician if the employer wishes to do so.

(Q.) *What will prevent a few doctors, such as those already engaged in industrial practice, from employing more salaried assistants and corraling a major part of the employed patients in California, leaving the balance of the medical profession worse off than before this plan was adopted?*

(A.) First, the trustees intend to make such rules as are necessary to prevent this situation from arising; second, the most effective preventive, however, will be the unwillingness of the average doctor to assume the financial responsibility necessary to employing assistants, enlarging his office, etc. It is also unlikely that he would be able to make contacts with any particular group of patients, since there would be no particular benefit to the patient and since most of them have their own idea about their doctor.

(Q.) *What incentive is there in it for any man to do more than render a minimum of service to a maximum number of patients or to acquire any special skill or training above the average?*

(A.) This question does not seem very sound. The answer is, of course, that it is the same incentive that makes a man render more than a minimum of service, etc. It all comes down to the fact that a man who renders a minimum of service and who does not acquire any special skill or training will not be a very successful doctor whether under this plan or in the practice of medicine as it has always been practiced.

(Q.) *Does this plan involve the solicitation of patients?*

(A.) No. Solicitation in the ethical sense means the asking of a person to become the patient of a particular doctor. There probably will be solicitation not to become patients of any particular doctor or doctors, but to associate themselves in a common enterprise which will enable them to pool their funds so that when they need hospital or medical care the physician and hospital of the patient's choice may be paid for out of the pooled funds. There is no sense whatever in which such a proposal could be called a solicitation of patients.

(Q.) *Isn't it unethical to advertise?*

(A.) Of course it is, when the advertisement is that of a physician or group of physicians seeking patients, but not when the advertisement is that of an organization inviting people to become members so that the organization may pay some doctor for taking care of some patient. In other words, California Physicians' Service has no medical services to offer or to sell; being an organization it could not have patients and it does not propose to render medical or hospital care. All that the organization proposes to do is to pay for hospital and medical care when such care is given by a physician and hospital chosen by the patient from the funds of the beneficiary members which it holds in trust and administers for this purpose.

(Q.) *Many people are saying that the fees will be very small.*

(A.) This is a pure assumption not founded on any particular fact. There is no reason to believe that if the organization is successful the fees paid will not be very adequate for the class of patient it is supposed to serve.

(Q.) *Could California Physicians' Service ever take care of groups of people unable now to pay for their medical service?*

(A.) Yes. The organization has the power to contract with Federal, state or local governments or any agencies thereof to furnish medical care to any groups or individuals for whose care they may be responsible.

(Continued on Page 52)

IODOBISMITOL *with Saligenin*

. . . for the patient with early syphilis
. . . for the patient who is sensitive to arsenic

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A RECENTLY PUBLISHED clinical study[1] of combination bismuth therapy includes the comment that: "One of the problems of bismuth therapy for syphilis is to achieve a rapid rise of the metal in the blood stream to a therapeutic level and to keep it there without too great hardship on the patient. . . . This we believe we have achieved by the combined use of iodobismitol or sobisminol and weekly injections of bismuth subsalicylate. . . . Such a form of bismuth therapy would be particularly useful in the acute stage of syphilis when the patient is sensitive to arsenic and it is necessary to rely on other antisyphilitic measures. Moreover, for the patient with early syphilis, who is just starting therapy, this schema might be employed in the first course of bismuth therapy when the clinician is desirous of dealing a heavy blow to the spirochetes from another angle than that of arsenic."

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[1] *Jl. A. M. A.* 111:2175 (Dec. 10), 1938.

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CALIFORNIA PHYSICIANS' SERVICE

(Continued from Page 50)

(Q.) *Is it planned to furnish medical and hospital care for families of beneficiary members?*

(A.) Yes, on the basis of small additional fees to be determined upon.

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Solomon, P.; Mitchell, R. S. and Prinzmetal, M.: The Use of Benzedrine Sulfate in Postencephalitic Parkinson's Disease —*J. A. M. A.*, 108:1765, May 22, 1937.

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STATE MEDICAL LEGISLATION

(Continued from Text Page 247)

sick or afflicted, which is intended or has a tendency to deceive the public or impose upon credulous or ignorant persons and so be harmful or injurious to public morals or safety constitutes unprofessional conduct within the meaning of this chapter."

A. 1574 proposes to make it a felony for any person to sell, dispense, administer or prescribe dinitrophenol for any purpose.

S. 817 proposes to restrict the retail sale and distribution of "any registered, trade-marked or copyrighted preparation or compound registered in the United States patent office" containing barbital to sale or distribution on the prescription of a licensed physician, dentist, or veterinarian. The present law imposes such a restriction on the sale of such a registered, trade-marked, copyrighted preparation only when it contains more than fortly grains to the avoirdupois or fluidounce.

S. 990 proposes to create the dental corporation of California, which is to consist of all licensed dentists and licensed dental hygienists in the state. The corporation is to be governed by a State Dental Board, whose members are to be selected eventually by members of the corporation. The present members of the Board of State Dental Examiners are to constitute the first State Dental Board, but as their terms expire they are to be replaced by persons selected by the corporation. The State Dental Board is to exercise all the rights and assume all the duties now in the Board of Dental Examiners. The bill also proposes to repeal the existing laws relating to the practice of dentistry and to enact an entirely new dental practice act. This bill, so far as it will integrate the dental profession, is quite similar in theory and set-up to so-called bar integration acts in force now in a number of states.

S. 1183 proposes to regulate the use of x-rays and x-ray appliances in connection with the examination of the jaws, teeth, alveolar process, gums, and the immediate adjacent structures of living human beings, as an aid to the diagnosis and treatment of diseases and lesions pertaining thereto. The bill proposes to create a dental x-ray qualifying committee to determine the qualification of applicants for permits authorized by the bill and to report the qualifications to the Board of Dental Examiners, which on the recommendation of the committee will issue such permits to qualified applicants. Two permits are proposed by the bill: first, an unlimited permit, the holder of which is to be called a dental roentgenologist and is to be authorized to diagnose and treat the diseases and lesions of the jaws, teeth, alveolar process, gums, and immediate adjacent tissues by means of x-rays or radiographs and to own, possess, or operate x-ray devices or x-ray laboratories; second, a limited permit, the holder of which is to be called a dental radiographer and is to be authorized to own, possess or operate a dental x-ray laboratory and to render technical descriptions of the shadows visible in roentgenograms to those licensed by law to diagnose ailments and treat the sick. The bill specifically provides that it is not to be construed to prohibit the ownership, possession or operation of x-ray devices used for the lawful diagnosis and lawful treatment of persons by licensed physicians, dentists, osteopaths, drugless practitioners or chiropractors.

A. 1307 proposes stated state and county aid to persons convalescing from tuberculosis. A person is to be deemed convalescing until he is able to return to the regular employment in which he was engaged prior to contracting tuberculosis.

A. 1712, to amend the law authorizing the organization of corporations to operate nonprofit hospital service plans, proposes in effect to permit such corporations to enter into contracts covering the "indemnification of the beneficiary or subscriber for the costs and expense of professional medical service rendered in connection with hospitalization."

A. 1796 proposes to prohibit the manufacture, advertising, sale or transportation of adulterated, mislabeled, or misbranded cosmetics and to regulate the traffic in cosmetics and complexion soaps.

A. 1874 proposes a system, under the supervision of the State Department of Public Health, for providing medical care, including medical, dental, nursing and hospital care, and the supplying of pharmaceutical and therapeutic appliances to needy persons, the cost of which is to be apportioned between the state and the counties. The bill specifically provides that, subject to the rules and regulations adopted by the department, "medical care shall be provided . . . to any resident of the state who has not sufficient income . . . to provide himself and his dependents with proper medical, dental, nursing, hospital, pharmaceutical,

(Continued on Page 56)

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STATE MEDICAL LEGISLATION

(Continued from Page 54)

and therapeutic appliance care, without depriving himself or his dependents of necessary food, clothing, shelter, and similar necessities of life."

S. 657 proposes to establish a health and safety code, which contains provisions relating to, among other things, (1) the duties and rights of the State Department of Health and local health departments and officers; (2) the regulation of clinics and dispensaries and maternity hospitals; (3) the quarantine laws of the state; (4) the maintenance of tuberculosis hospitals by governmental subdivisions; (5) sanitation and sanitary districts; (6) dead bodies, their burial, removal and disinterment, including the disposal of unclaimed dead bodies; (7) cemeteries; (8) vital statistics; and (9) the regulation of the possession and distribution of narcotic drugs.

Necessity of Reopening Abdominal Surgical Wounds Is Decreasing.—Reopening of abdominal surgical wounds and postoperative hernia are on the decrease, Albert O. Singleton, M.D., and Truman G. Blocker, Jr., M.D., Galveston, Texas, point out in *The Journal of the American Medical Association* for January 14.

They state, in summary, that this is due primarily to more study of the problems involved in making and closing wounds, and to the more successful postoperative care due to the increasing use of gastric suction, obviating vomiting and distention by gas.

Disruption of wounds and postoperative hernia in the upper part of the abdomen, with their distressing consequences, can be almost completely eliminated by the use of carefully made anatomic incisions. A transverse abdominal incision decreases the likelihood of hernia and disruption of abdominal wounds.

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Protein (N × 6.25)...	32.6
Fat	0.8
Calories per ounce....	40
Sodium Chloride......	11.1
Phosphorus as P......	2.62
Potassium as K.......	2.18
Calcium as Ca........	0.098
Iron as Fe...........	0.048
Magnesium as Mg....	0.13
Copper	0.00275
Manganese	Distinct Traces

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The simple uses are (a) a scant teaspoonful to a cup of hot water, (b) one-half teaspoonful to a cup of hot milk and (c) in broth or soup. It may be given several times throughout the day and before retiring.

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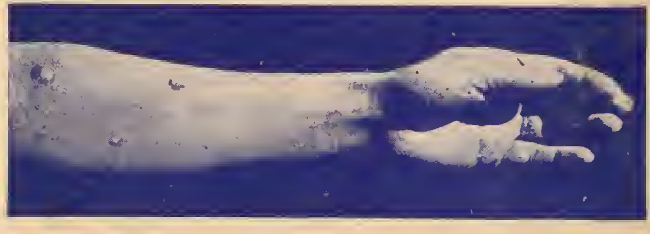

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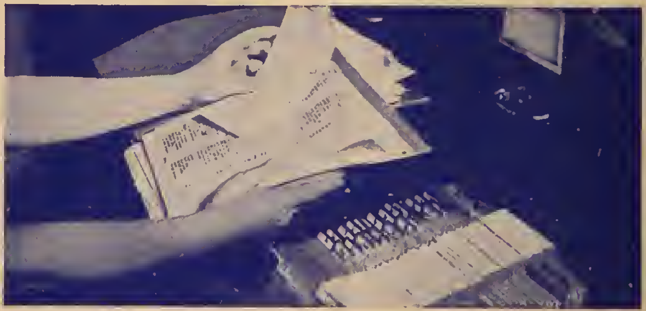

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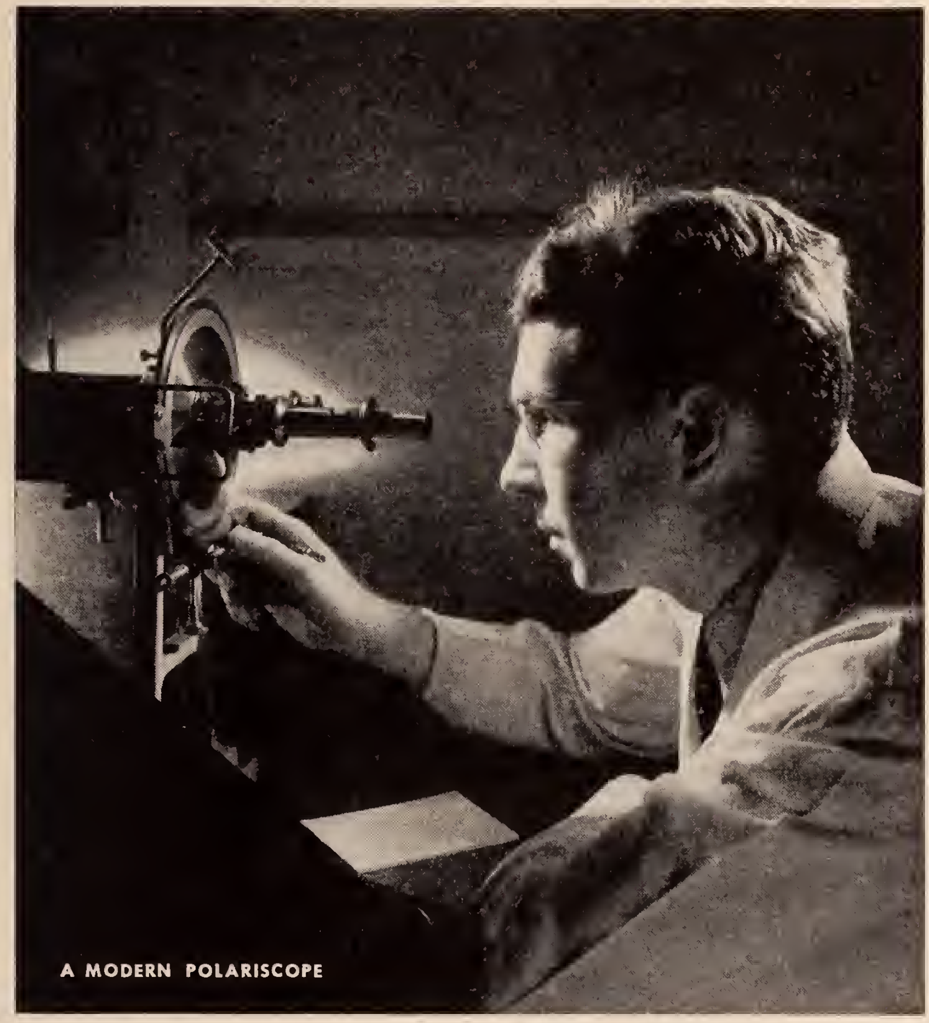

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Weigand, F. A.: Diuretic Action of Intravenous Sodium Dehydrocholate, J.A.M.A., 105: 2034 (Dec. 21) 1935.

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Secretary, Clifford E. Dieterich, 1306 Pomona Avenue, Crockett.

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Imperial County Medical Society

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Secretary, William A. Clarke, Holtville.

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Fourteenth Floor, Medico-Dental Building, 233 A Street, San Diego

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(Roster lists continued on advertising page 6)

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Vitamin C Foods.—Forced feeding of excess quantities of vitamin C foods in the treatment of rheumatic fever should be avoided, research experts of the United States Public Health Service declared, because of the possibility of neglecting the complete nutrition of the patient.

While lack of vitamin C in children's diets is an important cause of scurvy, they said, it is not an essential factor in the development of rheumatic fever, most common incitant of heart disease in children.

Dr. M. P. Schultz, Surgeon, United States Public Health Service, and others, described their study of the development of the fever in a summary, "Catalytic Potency of the Blood in Rheumatic Fever," in *Public Health Reports* for March 3, 1939.

"When the idea is held," they said, "that the administration of very large quantities of orange and lemon juice constitutes a single 'specific' treatment of the disease, such treatment may be carried to extremes, and the complete nutrition of the patient suffers because he comes to exist almost exclusively on such a diet."

The cause of rheumatic fever is unknown. Animal experiments have suggested that the occurrence of scurvy in children, due to an insufficient amount of vitamin C in their food, may be an essential factor in development of the disease. The fact that it occurs chiefly in growing children needing relatively large supplies of this vitamin, that it is more common in late winter and early spring when fresh fruits and vegetables are most expensive, that it is most uncommon in the tropics where these foodstuffs may be more easily had, and that in temperate climates it is essentially a poor man's malady since he may not be able to afford a varied diet—all these have lent plausibility to the suggestion.

Those who have investigated the amounts of vitamin C in patients with rheumatic fever, however, do not agree concerning the importance of scurvy as a cause of the fever.

The ability of the blood to resolve hydrogen peroxid into its component parts, oxygen and water (due to the presence of the enzyme catalase), is known to vary under certain conditions. In scurvy, for example, it is low. The present research would indicate, however, that there is no difference between the catalytic power of the blood in patients with rheumatic fever and those suffering from other febrile ("fever") diseases.

This affords further evidence, said Doctor Schultz, that a deficiency in vitamin C is not essential to the development of rheumatic fever, and this conception is of practical importance in planning the treatment of such patients. It indicates that, while it is true that adequate amounts of the vitamin should be supplied, the forced feeding of excess quantities should be avoided.

In this connection, according to Doctor Schultz, the literature indicates that rheumatic fever very rarely occurs in diabetics ("Glucose Tolerance in Rheumatic Fever," *Public Health Reports*, February 24, 1939). This has suggested that abnormalities in the utilization of sugar might account for development of the fever in afflicted individuals. One test of the patient's ability to use sugar is the determination of its concentration in the blood after a large amount is taken by mouth.

"In diabetics under the conditions of these tests," said the Report, "much sugar appears in the blood; in other rarer endocrine disturbances the reverse is true. Patients with rheumatic fever, however, when tested, did not differ in their behavior from those suffering with other febrile diseases; and the experiments afford no proof of association between the patient's ability to utilize sugar and the development of rheumatic fever."

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Treatment of Poison Oak.—Poison oak is a cause of many disabilities among workmen, and may be regarded as an important factor in the industrial hygiene program. Dr. J. P. Russell, Chief of the Industrial Hygiene Service of the California State Department of Public Health, has provided the following information relative to the prevention and treatment of poison oak:

Wherever practicable, gloves and masks should be worn to protect the exposed skin from contact with the plant.

Personal hygienic measures, particularly washing thoroughly with soap and hot water immediately after contact or exposure, is usually effective in preventing a resulting dermatitis.

Most authorities recommend, as a prophylactic measure, the local application to the skin of a mild oxidizing agent, such as a 5 per cent ferric chlorid solution, or a 2 per cent aqueous solution of potassium permanganate, immediately after exposure. These preparations, while often effective in preventing the development of the dermatitis, have the disadvantage of producing a marked but transient discoloration of the skin.

An alternative preventive measure, which is also based on the oxidization of the toxic element in the plant, and which has been successful in many cases, is the application to the skin of a dusting powder, composed of 10 per cent benzoyl peroxid in talcum powder, prior to or immediately after exposure to the plant. This method is recommended by Doctor Leake as being preferable to the ferric chlorid or potassium permanganate, in that it does not discolor the skin: however, in using this preparation, precaution must be taken to avoid any open flame, as the powder is inflammable.

The local application to the skin of equal parts of glycerin and water, following exposure, has also been recommended.

A bulletin has been issued by the United States Public Health Service, describing the etiological symptoms, prevention, and treatment of poison oak dermatitis.

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Presents briefly, in syllabus form, essential data for practical application in the clinical management of patients with cancer. The methods outlined have been assembled from many sources with the coöperation of all the active members of the Tumor Clinic.

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The Institutions here listed have announcements in this issue of CALIFORNIA AND WESTERN MEDICINE. For Index, see advertising page 8.

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Most Poor City Workers on Deficient Food Diets.—When food budgets are very low, city workers buy little more than hunger-staying diets which, for the most part, are deficient in needed minerals and vitamins, as shown by an analysis of four thousand diets of employed wage-earners and low-salaried clerical workers in forty-three industrial center cities in eight different parts of the country.

The analysis was made by Dr. Hazel K. Stiebeling and Esther F. Phipard of the Federal Bureau of Home Economics as a Works Progress Administration project, using food records collected by the United States Bureau of Labor Statistics from 1934 to 1937.

When families could afford only $1.25 to $1.87 a person per week for food, which was the case for more than one-third of the Southern negro families and from one-fourth to one-tenth of white families in all regions, they bought mostly food that "sticks to the ribs." When the food budget rose to $3.75 to $4.37 a person a week, they purchased nearly twice as much milk, and from two to three times as much butter, eggs, green and yellow vegetables, meat and poultry, or fish.

There was, however, considerable variation in amounts of these foods consumed by families in the different regions. Pacific Coast families ate more fresh vegetables and consumed about twice as much as families in the East North Central cities, where canned foods, especially corn and tomatoes, were popular. The Pacific Coast families, for instance, ate twenty-five pounds of lettuce a person a year and twenty-three pounds of carrots. They also ate more citrus fruit—twice as much as white families in North Atlantic cities and nearly three times as much as white families in East South Central cities.

Potatoes are one of the most popular single foods, the study showed. Whatever the amount spent for food, quantities of potatoes were consumed. Nor were they only a low-income food, for with rising food expenditures even more was spent for potatoes. North Atlantic families were the heaviest potato eaters—133 pounds a person a year at the lowest food expenditure level studied and 162 pounds at the highest. Southern white families bought about one-third as many sweet potatoes as white potatoes, and Southern negro families ate about equal quantities of each.

As was expected, bread varied less in quantity with changes in income. There were, however, marked differences in bread tastes in different regions of the country. Much more rye bread was eaten in the North Atlantic cities. They also ate more macaroni, a flour product. Pacific Coast families ate more dark breads—one-fifth of the bread purchases being either whole wheat or rye.

Southern families, particularly negroes, showed a decided preference for home-baked breads, buying from two to three times as much flour and cornmeal as families in other regions.

Families in North Atlantic cities ate 87 pounds of meat, poultry and fish a person a year at the lowest food spending level studied, and 246 pounds at the highest. Families in all regions ate more beef and veal than pork or lamb.

In every region, families spending little for food used only a small quantity of milk. In the South, where average food expenditures are lower than in the North and West, milk consumption also was lower. Southern white families used only 98 quarts a person a year compared with averages from 109 to 126 quarts in other regions. Southern white families, however, bought as much milk as other white families, when their food expenditures were the same.

Complete details of the study are included in Circular No. 507, of the United States Department of Agriculture. It may be had from the Superintendent of Documents. Washington, D. C., at 15 cents a copy.

Never attempt to bear more than one kind of trouble at once. Some people bear three kinds—all they have had, all they have now, and all they expect to have.—Edward E. Hale.

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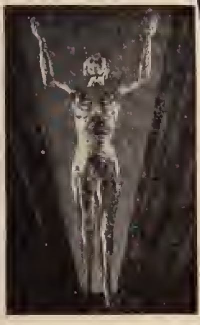

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Heart and Functions Featured at Golden Gate Exposition.—How many times a year does the heart beat? How much does the heart accomplish in one minute, a day, a year? Why may the heart be likened to an automatic double pump? Exactly how does enlargement affect the heart?

These and many other questions pertaining to the cardiac system are answered by means of simple text, powerful drawings, animations, and unique lighting effects, at the 1939 Golden Gate International Exhibit. Sponsored by Ciba Pharmaceutical Products, Inc., of Summit, New Jersey, the display, "The Heart and Its Functions," will illustrate the different types of corpuscles in the blood and will explain such interesting phenomena as arteriosclerosis and blood pressure.

Importance of Physician.—"The Heart and Its Functions" display is truly as modern as "The World of Tomorrow." It was constructed by Ciba after months of careful study in accordance with advice and instructions from members of the medical profession, with the idea of presenting the physician's viewpoint and importance to the public. The scope of the exhibit may be glimpsed by the subjects covered. These include the blood, the blood plasma, the volume of blood, blood transfusion, the circulatory system, the heart as an automatic double pump, adjustment of the heart, the steadfast heart, the pulse, arteriosclerosis, cause of blood flow, blood pressure, x-ray of heart enlargement, the doctor.

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Life Expectancy.—Babies born in 1938 have a 62-year lease on life.

The total "life expectancy at birth" for the United States last year, according to computations based on certain estimated factors and released by the United States Public Health Service, was sixty-two years. This figure compares with an expectancy of 60.26 in 1931, and 60.9 as estimated for 1937.

While still somewhat below the biblical promise of "three score and ten," the life expectancy now is almost twice as great as it was one hundred years ago. For the seven years since 1931 a gain in expectancy of 1.74 years is indicated, while a gain of 1.1 years is shown in 1938 over 1937.

The expectancy of life at birth, it is explained, "is the average age at death of a hypothetical group of persons each of whom is subject to the same age specific mortality rates throughout his lifetime."

The important factors in the computation of life tables are those age specific death rates which are based upon the age distribution of the population and on the deaths by ages. Apparently, the actual average age at death of persons in the general population should be the life expectancy at birth. This is not likely to be true, however, since the age distribution of the living population will probably not be identical with that of the stationary population which is a function of the computed expectancy.

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BOOKS RECEIVED

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A Manual of Roentgen Diagnosis. By Kenneth S. Davis, M. D., Los Angeles. Cloth. Pp. 160, illustrated. Lithostat Reproduction by Cossitt & Co., Inc., San Francisco, 1938.

Jefferson the Forgotten Man. By Samuel B. Pettengill, Member of Congress, with a foreword by Douglas Johnson. Cloth and Paper. Pp. 249. Price, in cloth, $1.50; in paper, $1. New York: America's Future, Inc., 1938.

Oh, Doctor! My Feet! By Dudley J. Morton, M. D., Associate Professor of Anatomy, College of Physicians and Surgeons, Columbia University; author of "The Human Foot: Its Evolutionary Development, Physiology, and Functional Disorders." Cloth. Pp. 116. Price, $1.50. New York: D. Appleton-Century Company, 1939.

Cardiovascular Disease in General Practice. By Terence East, M.A., D.M.Oxon., F.R.C.P., Lond., Physician and Physician-in-Charge of Cardiological Department, King's College Hospital; Physician Woolwich War Memorial Hospital; Sometime Examiner in Pathology, Conjoint Board; and Radcliff Traveling Fellow, Oxford University. Cloth. Pp. 206, with 43 illustrations. Price, $3.50. Philadelphia: P. Blakiston's Son & Co., Inc., 1939.

Bacteria, the Smallest of Living Organisms. By Dr. Ferdinand Cohn (1872). Translated by Charles S. Dolley (1881). Introduction by Morris C. Leikind. Board. Pp. 44. Price, $1. Baltimore: The Johns Hopkins Press, 1939.

The New International Clinics. Original Contributions: Clinics; and Evaluated Reviews of Current Advances in the Medical Arts. Edited by George Morris Piersol, M. D., Professor of Medicine, Graduate School of Medicine, University of Pennsylvania, Philadelphia. Volume 1, New Series Two. Cloth. Pp. 312, illustrated. Philadelphia: J. B. Lippincott Company, 1939.

Surgical Treatment of Hand and Forearm Infections. By A. C. J. Brickel, M. D., Departments of Anatomy and Surgery, Western Reserve University. Cloth. Pp. 300, with 166 Text Illustrations and 35 Plates, Including 10 in Color. Price, $7.50. St. Louis: The C. V. Mosby Company, 1939.

Chronic Diseases of the Abdomen. A Diagnostic System. By C. Jennings Marshall, M. S., M. D. (London), F. R. C. S. (England), Surgeon, Charing Cross Hospital and Victoria Hospital for Children; Surgical Consultant, L. C. C. and Bromley District Hospital; Examiner in Surgery, London University and Victoria University, Manchester. Cloth. Pp. 247. Boston: Little, Brown & Company, 1939.

Our Sex Life. A Guide and Counselor for Everyone. By Fritz Kahn, M.D. Translated from the German by George Rosen, M.D. Cloth. Pp. 459. Price, $6. New York: Alfred A. Knopf, 1939.

Whence? Whither? Why? A New Philosophy Based on the Physical Sciences. By Augusta Gaskell. Introduction by F. K. Richtmyer, Professor of Physics, Cornell University, Dean of the Graduate School. Cloth. Pp. 312. Price, $2.50. New York: G. P. Putnam's Sons, 1939.

Surgical Anatomy. By C. Latimer Callander, M. D., F. A. C. S., Associate Clinical Professor of Surgery and Topographic Anatomy, University of California Medical School; Member of Founders' Group of the American Board of Surgery; Member of American Association of Traumatic Surgery; Associate Visiting Surgeon to the San Francisco Hospital. With a Foreword by Dean Lewis, M. D., Sc. D., LL. D., F. A. C. S. Second Edition, Entirely Reset. Pp. 858, with 819 illustrations. Cloth, $10 net. Philadelphia and London: W. B. Saunders Company, 1939.

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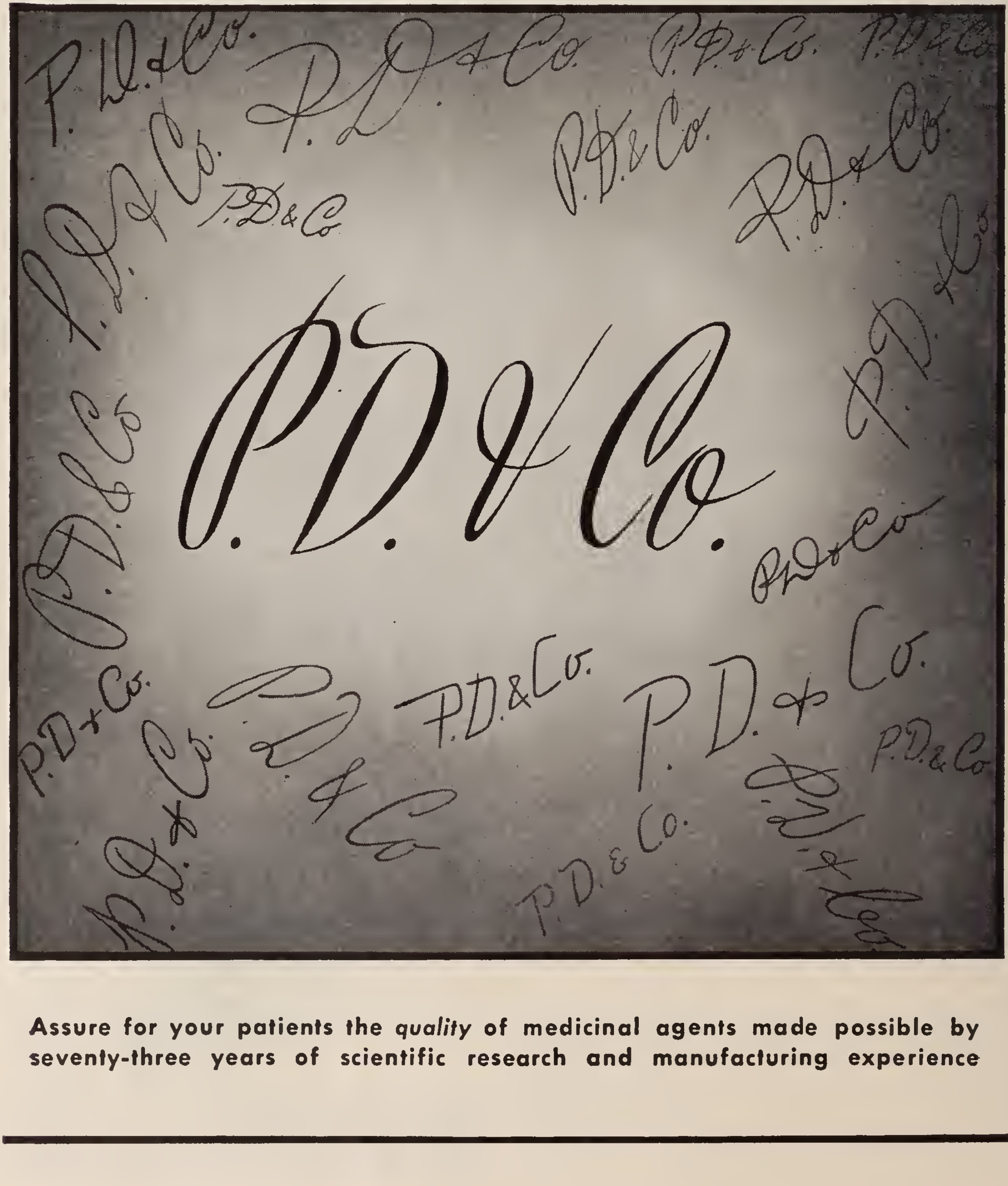

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MEDICAL DIRECTORS, PASADENA, CALIFORNIA

TWENTY-FIVE YEARS AGO

(Continued from Text Page 320)

wait until this plan is perfected in its details and the matter can be passed upon by the State Society at the April meeting. We must recognize the fact that the law is here and that, in some form, it is here to stay. It is very much better for us to work in harmony with the Insurance Commission and with the companies and get things into as good shape as possible than to fight them or be nasty and say that we won't play because certain things ought not to be so; it is not a question of what ought or ought not to be, but of what actually is, that we have to consider. . . .

✓ ✓ ✓

Precipitate Publication.—Great patience, circumspection, testing and retesting of results on a sufficiently numerous series so as to eliminate as much as possible the element of chance, coincidence or other sources of fallacy, denote the trustworthy investigator. A beautiful example of the honest skepticism and rigid self-criticism which the real scientist imposes upon himself when drawing conclusions from complex phenomena is preserved for all time in Darwin's "Origin of Species." In Koch's celebrated rules there is contained an admonition which no inquirer into the etiology of disease should presume to ignore. Wassermann and Noguchi have exhibited exemplary patience, to say nothing of other qualities, before publicly professing anything like certitude as to the value of their researches. And, lest the urgency of our need for therapeutic progress be advanced in extenuation of premature publication of alleged discoveries in this branch of science, the now famous number "606" gives us an arithmetical measure of the labor Ehrlich performed before submitting to the world his remedy for disease. . . .

Economic Waste on a Large Scale.—Some time ago the Journal commented on the great economic waste involved in the maintenance of two medical departments connected with two universities in California. There is no demand for two schools of this class and there can be no justification for their existence, based on anything but personal motives. The amount of money expended in the duplication of effort, totally unnecessarily, is already very great and will be an increasing amount reaching into the millions, as time goes on. . . .

✓ ✓ ✓

Closing the Hospital.—Some years ago the Journal commented on the fact that improved medical training and the betterment of medical work as a result of county medical society organizations were having a marked effect in the increase of the small hospital. All over the state, small hospitals were formed in communities that had previously been without any place where a very sick person could be properly treated or operated upon. The local men were studying up their surgery and taking postgraduate work and becoming competent to handle all the average surgical work that came along instead of sending the patient on a long, tiresome and often dangerous journey to a center where there was a hospital and a surgeon to operate. Last year we sent letters to a number of these hospitals that had formerly advertised in the Register and Directory, and several letters like the following were received in reply:

"We have decided to discontinue our hospital owing to the eight-hour law for nurses and, therefore, will not take the usual advertisement in the Register and Directory."

As a result of this law, which does not seem to do anyone the slightest good, and which an overwhelming majority of the student nurses themselves did not want, a number

(Continued on Next Page)

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CALSO is not a laxative and contains no sulphate

SPARKLING PALATABLE

CALSO WATER CO.
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TWENTY-FIVE YEARS AGO

(Continued from Preceding Page)

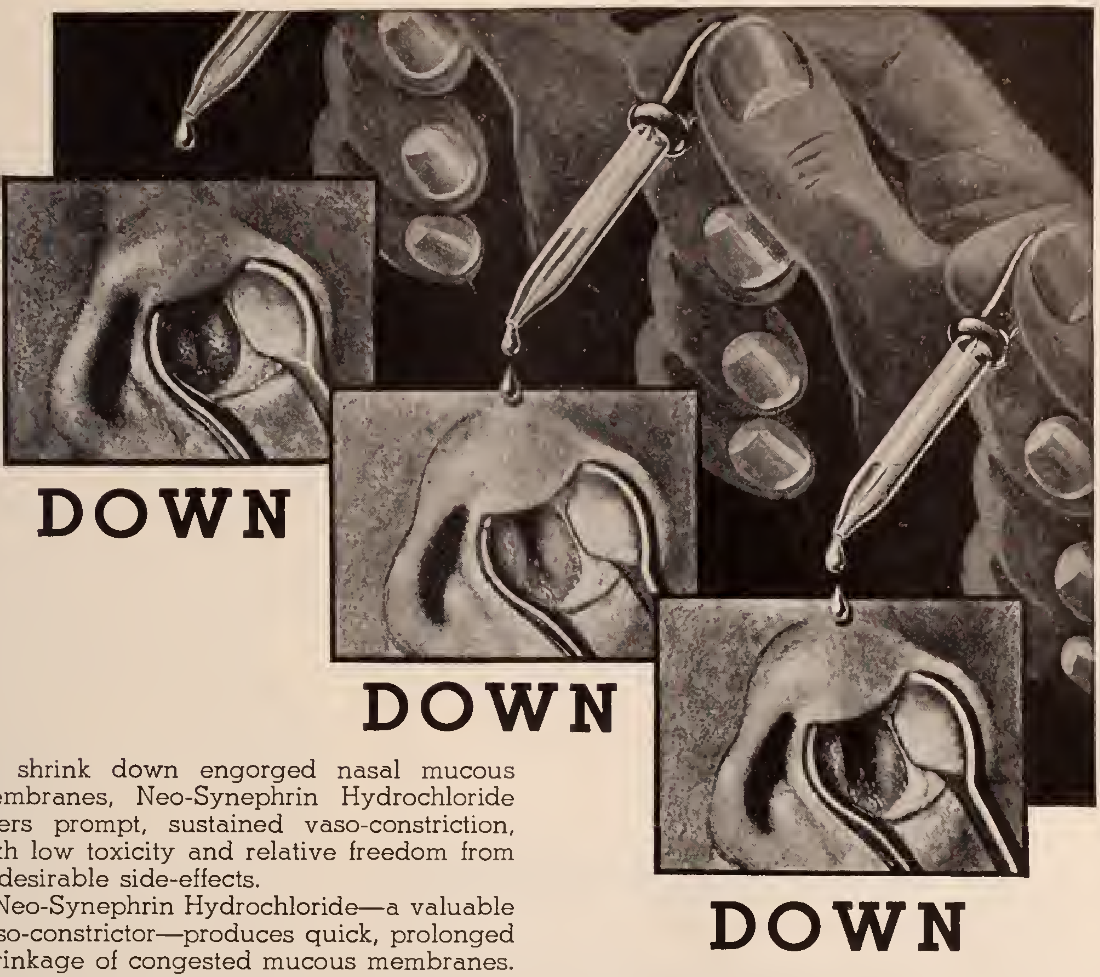
of small hospitals have closed their doors, citizens of the local community are thus deprived of the hospital advantages which they had had, a large number of women are deprived of their occupation and of the chance to be educated so as to go out into the world and earn their living in a truly womanly calling; and what good has resulted to anyone? If someone who knows will only rise up and point out to us the slightest good that has resulted, we will be profoundly thankful. We seem to have gone mad on the subject of making laws for anybody and everybody, whether they want them or not!

From an Original Article on "The Psychological Study of Mentally Defective and Otherwise Exceptional Children," by Ernest Bryant Hoag, M.D., Los Angeles.—In ancient times the feeble-minded, like the insane, were objects of derision, cruelty and persecution, and were often summarily disposed of.

At a later period, especially during the Middle Ages, these unfortunates were treated with less severity and became in many instances the "fools and jesters of the royal courts." By some, these idiots and imbeciles were regarded with superstitious respect, and it is said that the great astronomer, Tycho Brahe, listened with reverence to the meaningless chatter of a fool who had become a constant companion in his observatory.

In this incident we are reminded of the fact that the German psychologist, Freud, who is just now occupying the center of the psychological stage, would have us believe that the ravings of the maniac are all of significance if we could but read aright the workings of his disordered

(Continued on Page 18)



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TWENTY-FIVE YEARS AGO

(Continued from Page 16)

subconscious mind, and we cannot but wonder whether Tycho Brahe and Freud are not entitled to about the same amount of respect in this particular connection. . . .

Various classifications of the mentally deficient have long been in use, but these have never given much evidence concerning intellectual potentiality, and have therefore been of relatively little value in establishing a prognosis. Since 1905, however, when Binet and Simon, two French psychologists, published their first intelligence scale, means have been at hand for the successful classification of mental capacity, and there is at present, therefore, no longer any excuse for failure to do so. The physician who is today ignorant of these relatively simple psychological tests is in much the same position as one who is unacquainted with the Wassermann reaction or of anti-typhoid vaccination. . . .

Then came Binet with his simple device of arranging the tests in series or groups according to their difficulty as determined by age differences in performance. His data were of very limited extent and rather carelessly elaborated, but the advantages of this procedure are every day becoming more apparent and are rapidly making possible a clinical child study. . . .

From an Original Article on "The Therapy of Typhoid Fever—A Critical Review," by E. O. Jellinek, M. D., San Francisco.—In spite of the advance in the treatment of morbid conditions, brought about by the steadily growing knowledge in bacteriology, sero- and chemotherapy, we find ourselves still confronted with the painful fact that for the vast majority of diseases we have no specific treatment. Even the most optimistic disciple of science, when he reflects upon the problem to be solved, will realize that the whole question of the specific serum, vaccine, or chemotherapy of the various infections, is still in its infancy, and that it may take the efforts of generations to win supremacy over the world of microörganisms with their unlimited power of proliferation. . . .

From an Original Article on "X-ray Dosage," by Howard E. Ruggles, M. D., San Francisco.—A simple, accurate method of measuring dosage of x-rays is needed, not alone in treatments (which should be given only by experts), but equally as much in radiography and fluoroscopy, so that the safe limits of exposure may be determined.

The methods in general use are clumsy and more or less inaccurate, especially those which depend on color changes in tablets which are compared with standard tints. Different operators vary considerably in their estimation of the end points and, furthermore, it is not always convenient or possible to include one of these meters in every exposure of any length.

A much simpler way of getting at it depends upon the fact, especially emphasized by Sewall Cabot of Boston, that the quality and quantity of radiant energy given off by a

(Continued on Page 20)

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TWENTY-FIVE YEARS AGO

(Continued from Page 18)

tube depends absolutely upon the quality and quantity of electrical energy supplied to it. . . .

From an Original Article on "Vital Statistics," by E. Goodman, M.D., San Francisco.—In these times of intensive research and rapid-fire discoveries, it appears like foolhardiness or presumption for one of the rank and file to comment on the ways and deeds of the powers that be; yet the greatest discoveries and thoughts sprang into being overnight, out of obscurity, to upset prevailing thoughts and conditions. . . .

My subject is Vital Statistics, and the object of my criticism the Government. Statistics, at best, is no sound criterion, for the reason that it does not take into consideration conditions and is just about as scientific as taking the specific gravity without regard to temperature and pressure, or prescribing digitalis without regard to the condition of the heart and collateral circulation. . . .

From an Original Article on "The Medical Situation of the New Workmen's Compensation Act," by J. Rollin French, M.D., Los Angeles.—The new Workmen's Compensation law, which went into effect January 1, 1914, is a broad measure, relating to compensation insurance and industrial safety. It establishes an industrial accident commission, to be composed of three members, to administer its compensation features, to maintain a mutual insurance fund for the state, and regulate provisions relative to safety.

All classes of employment come under this act, excepting farm labor and domestic service, which are at present protected by common-law liability, but may elect to come under the Boynton Act. . . .

From an Original Article on "Some Principles Governing the Indications for Cesarean Section," by Alfred Baker Spalding, M.D., San Francisco.—Good results can be obtained in abnormal obstetrics if sufficient attention is given to the patient during pregnancy, and if the patient is confined by a competent physician in a hospital devoted exclusively to obstetrics. Well-conducted maternity hospitals are able to maintain a maternal mortality of a fraction of one per cent, a fetal mortality of less than five per cent, and a general morbidity rate of under fifteen per cent. This is an important point to consider in discussing the indications for such a valuable operative procedure as is cesarean section because the relative values of all obstetrical operations are based upon experience obtained in such perfected institutions. . . .

In reviewing my records in preparation for this paper, I find that I have operated myself or have assisted others with this operation in twenty-five instances. In every case there existed a grave danger for the mother or child which was met successfully, so far as all the mothers were concerned, by the cesarean operation, and yet in some instances I am convinced delivery could have been accomplished by other procedures. . . .

There is no doubt that the sphere of indications for cesarean section is growing and there is considerable danger that the pendulum will swing too far toward the operative side. It should not be forgotten that even in good hands the operation carries with it a maternal mortality in the neighborhood of five per cent, or ten times the maternal mortality obtained in confinements generally.

From an Original Article on "Hygienic Shoeing—Anatomical Facts versus Convention and Style," by C. C. Crane, M.D., San Francisco.—The evidence to be submitted consists, in the main, of four facts:

(Continued on Page 22)

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From the very beginning of "The Most Important Year," the infant requires a carefully balanced diet for the healthy development of bone and tissue structure.

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TWENTY-FIVE YEARS AGO

(Continued from Page 20)

1. In the examination of the feet of one thousand adult Puerto Ricans, who had never worn shoes, virtually not one presented evidence of foot illness or deformity.

2. In the examination of the feet of one thousand individuals, who have worn shoes for a considerable period of time, and in whom the feet are not troublesome—that is, are symptomless—it is rare to find a foot that is in normal condition.

3. A very large percentage of shoe-wearing people present evidence of foot trouble which is promptly relieved by shoeing in accordance with anatomical facts.

4. After a canvass of practically all of the local shoe stores, the hygienic shoe is found to be conspicuously infrequent. . . .

From Society Reports: Tulare County.—The Tulare County Medical Society, at its regular monthly meeting held February 10, passed the following resolution, this being, with the exception of the last paragraph, like the one passed by the Los Angeles County Medical Society:

Whereas, The State Industrial Accident Commission, in order to carry out the provisions of the recently enacted Workmen's Compensation Law of California, which is intended to safeguard the economic efficiency and prosperity of citizens engaged in industrial occupations, an object with which the ethical medical profession is in deep sympathy, as is evidenced by the service of its members in the past, in caring for many of the unfortunate sick without cost, in hospitals, dispensaries, and in private practice; . . . now, therefore, be it

Resolved, By the Tulare County Medical Society that this society, because of the above and other reasons, respectfully requests the California State Industrial Accident Commission to pass a resolution and print on the fee table they have submitted a statement to the effect that the Commission understands fully the difficulty and inequality of an inelastic fee table for medical and surgical services, and that the minimum fees presented by the Commission are so made because of the limited resources of the State Industrial Accident Fund, and because of the comparatively small financial income of the bulk of the citizens whom the industrial law is especially intended to protect and benefit. . . .

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BOARD OF MEDICAL EXAMINERS

(Continued from Text Page 320)

been excluded from the courtroom. . . ." (San Diego *Union*, March 1, 1939.)

"On complaint of the State Medical Board, John Alden Standish of 345 North Alta Vista Avenue and William J. Clancy, said to be his associate, were arrested yesterday afternoon on a warrant issued by Judge John A. H. Sturgeon in justice court, charging the pair with violation of the Business and Professional Code of the State of California. The charges, according to court records, were based on certain practices of Standish and Clancy in the sale of herbs, as a cure for certain ailments. Clancy was fined $100 or fifty days each on two counts, including the practice of medicine and the use of the title 'M. D.' without licenses from the State Board. . . ." (Monrovia *News-Post*, February 24, 1939.) Investigation discloses that one by the name of Dr. William James Clancy had his Wisconsin medical license revoked on June 28, 1935.)

"Camille C. Roumage, thirty-four, was arrested here yesterday by T. P. Hunter, Special Agent of the Board of Medical Examiners, and Officer P. O. Emerine of the Sacramento Police Department, who said Roumage had violated the Business and Professions Code of California. Specifically, the charge deals with the diagnosing and treating of patients without a certificate, the officers said. . . ." (Sacramento *Union*, February 26, 1939.)

"Two Salinas Chinese herbalists were at liberty today on $500 cash bail each after being arrested on charges of practicing medicine without licenses. The arrests were made late last night by Special Agent Joseph W. Williams of the State Board of Medical Examiners. According to the officer, Frederick Lee, thirty-three, and Henry Wong, forty-one, treated local residents for venereal diseases and ailments of the stomach, kidneys, and lungs. He confiscated a quantity of medicines he said the Chinese, operators of two establishments here, used in the treatment of their clients. . . ." (Press dispatch dated Salinas, February 25, and printed in the San Jose *Mercury-Herald*, February 26, 1939.)

"Dr. Lewis Robertson, Santa Cruz chiropractor, was last night held in the city jail in lieu of $500 bond on a charge of practicing medicine without a license. Robertson was arrested by Joseph Williams, special agent for the State Board of Medical Examiners, after he had allegedly given the investigator treatments outside the bounds of chiropractic practice. A similar charge, brought against Doctor Robertson last April, has not yet come to trial, Williams said, and it is possible the man will be faced with both charges when he is arraigned on Thursday." (Santa Cruz *Sentinel*, February 22, 1939.)

"Eugene Aureguy, private investigator who was a principal figure in the sensational Constance May Gavin-Flood case at Redwood City, was called before the San Francisco County Grand Jury yesterday to testify in the abortion death of Mrs. Betty Barsotti, twenty-four, at San Francisco on Monday. Aureguy said he has been retained by Dr. Reginald Grant, who treated Mrs. Barsotti at a hospital as soon as the physician saw Mrs. Barsotti's condition." (Burlingame *Advance-Star*, February 9, 1939.)

(Continued on Page 26)

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BOARD OF MEDICAL EXAMINERS

(Continued from Page 24)

"Brooklyn (New York) contractors have long been enmeshed in the tentacles of a wide-flung bribery ring operating in the Department of Housing and Building . . . Assistant General John Harlan Amen's staff revealed today. Coming on the heels of yesterday's sensational arrest of former Assistant Attorney-General Sol Ullman, who is under indictment for the alleged extortion of $13,000 in bribes from operators of a ring of Brooklyn medical malpractitioners, it was said 'some of the officials about to be indicted as "fixers," are involved in both extortion rings.' Among those are a former state assemblyman and an assistant district attorney, both of whom are alleged to have taken bribes in more than 2,000 cases of illegal operations on women. . . . Prior to his appointment by Governor Herbert H. Lehman to supersede District Attorney William F. X. Geoghan in an investigation of 'corruption and laxity of law enforcement' in Brooklyn, Amen was an Assistant United States Attorney-General in charge of the Brooklyn headquarters of the Government's Anti-Trust Division." (Press dispatch dated New York, March 11, and printed in the San Francisco *Examiner,* March 12, 1939.)

"Refugee German doctors whose licenses were canceled by decree of Adolf Hitler last year are eligible to take California State examinations provided the internship was begun before the decree was effective. . . . The ruling declared the decree of September 30 will not prevent German Jewish physicians and surgeons who started their internship prior to the issuance of the decree from being admitted to the state examinations, although state law requires graduates of foreign medical schools to hold licenses to practice in the country where the school is located to be eligible to take the state examinations. 'In view of the fact that the deprivation of the foreign license is based only on a political decree,' the ruling said, 'and was not due to any disqualification arising from any illegality or inefficiency in practice, or any mental, moral or physical deficiency . . . the Board of Medical Examiners should admit such applicants to the examinations on completion of internship.'" (San Francisco *Examiner,* March 11, 1939.)

"In its fourth month of operation, San Francisco's municipal employees' health service amassed a deficit so large that the one thousand doctors who rendered service to its members during January may expect to collect no more than 50 cents on the dollar for those services. Notice that the service has insufficient money to meet its January medical costs was served on the member doctors yesterday. . . . Although no direct comment came from doctors whose fees will be curtailed, it was generally believed that the failure of the health system to meet its obligations will be thoroughly discussed by directors of the County Medical Society in their meeting on Monday. . . . Announcement that January fees cannot be paid in full came as no surprise. Weeks ago, warning was served that December bills for medical service amounted to twice the sum available for their payment. . . . Since the plan went into effect in October, those assessments have yielded approximately $30,000 a month. Doctors who have agreed to take their fees from whatever is left after the medical director, hospitals, and laboratories are paid, received total payments as follows in the first three months: October, $13,433; November, $17,603; December, $19,829. . . ." (San Francisco *Examiner,* March 8, 1939.)

"An indictment, charging an attempt to cheat the United States Treasury out of $7,500 in income taxes by improper

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returns, was returned yesterday by the new Federal Grand Jury against Dr. Jackson L. Martin, 'suspended' medical man of Fresno. The taxes covered a four-year period from 1932 to 1936, according to Government figures. 'Doctor' Martin's license was revoked by the State Medical Board in 1928, following the exposé of an alleged abortion. Later he was arrested in Fresno by State Board operatives for practicing without a license. This case is still pending in the Fresno courts. Government figures show that Martin paid Clifford C. Anglim, Collector of Internal Revenue, $13,784 in March of this year. In Fresno, Martin expressed surprise at the indictment, saying he had settled for all disputed amounts and that he never had endeavored to 'cheat' the Government." (San Francisco *Chronicle*, March 8, 1939.) (Previous entries, December, 1928, and February, 1939.)

"Retrial of Dr. David C. Long, chiropractor, on charges of violating the Medical Practice Act because he was the attending physician at a birth, was begun before Municipal Judge Charles P. Johnson as selection of a jury got under way. The defendant, who was said by Defense Attorney Max Gilmore to have successfully served in more than one thousand obstetrical cases, is specifically charged with attending Mrs. Wilton Whitehouse of 1224 Slauson Avenue. Prosecutor Everett Leighton, Deputy City Attorney, contends that obstetrical cases necessarily involve the use of instruments, which is denied chiropractors under state law. At a former trial held before Judge Leo Aggeler, the jury was dismissed after it reported it was deadlocked, with a reported 10 to 2 vote for acquittal." (Los Angeles *Herald-Express*, March 7, 1939.)

"In Superior Court yesterday, a young doctor, his brilliant mind shackled by a craving for narcotics, pleaded for a chance to rehabilitate himself and salvage his career. Dr. William J. Reed, standing before Judge Steiger, after admitting his guilt as a violator of the State Narcotics Act, made the impassioned appeal. . . . Joseph O'Farrell, State Narcotics Agent, confirmed the doctor's statement of his operations. And records supported the prisoner's medical claims. 'I am going to send you to the Spadra State Hospital for addicts,' Steiger said. 'Go there as a patient, not as a criminal. Let them help you.' . . ." (San Francisco *Chronicle*, March 7, 1939.) Investigation reports indicate that Reed had mailed packages of narcotics from Iowa to California and that he assertedly was taking six grains daily.

Investigation reports relate that Dick Smith, after being arrested on a charge of violation of the Business and Professions Code on February 10, 1939, pleaded guilty before Justice of the Peace Albert L. Mayer at Firebaugh and was sentenced to pay a fine of $150, with an alternative of seventy-five days in the county jail, and given a six months' floater out of Fresno County.

Fresh Blood Should Be Used for Hemorrhage Due to Jaundice.—Only freshly drawn blood should be used for transfusions to combat the tendency to hemorrhage in jaundice, Jonathan E. Rhoads, M.D., and Lillian M. Panzer, Philadelphia, state in *The Journal of the American Medical Association* for January 28.

In their comparative study of "bank blood" and fresh blood they found that the prothrombin content (antihemorrhagic factor) of "bank blood" was greatly reduced. Blood that has been in the "bank" a week or more is practically useless in the treatment of the hemorrhagic tendency in jaundiced patients unless, of course, they are also treated adequately with vitamin K and bile salts.

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Actions Under New Drug and Cosmetic Law Provisions Increasing.—With the effective date of all the provisions of the Federal Food, Drug and Cosmetic Act now four months off, legal actions against dangerous drugs, cosmetics and devices have been mounting steadily, the Food and Drug Administration reports. Such dangerous items, by the terms of the new law, were subject to action immediately following the signing of the law on June 25, 1938. The other provisions will take effect on June 25, this year.

During January, two hair dyes were seized. They contained the highly irritating dye, paraphenylendiamin, and failed to carry in their labeling the cautionary statement prescribed by the law against use on the eyelashes and eyebrows and for making a preliminary skin test before use as a hair dye. The seizures involved thirty-eight packages of Madame Marva Hair Coloring, and seventy-six of Eau Sublime Instantaneous Hair Coloring.

Drug products seized because alleged to be dangerous under the conditions of use prescribed in their labeling were 10 bottles of Barmidon Tablets, containing aminopyrin; 23 bottles of Renton's Hydrocin Tablets, containing cinchophen; 92 bottles of Bad-Ex Salts, containing Tartar Emetic; and 1,107 ampuls of glucose solution, represented as sterile, but found to contain living bacteria and precipitated material.

Seizures of alleged dangerous devices involved five brands of nasal irrigation outfits, in these quantities: 119 of Nazoscope, 411 of Pen-E-Scope, 128 of Penetrex, 266 of Peranol, and 446 of Syn-O-Scope; and 3,078 nipple shields made of lead, a poisonous metal. . . .

Drug and medicinal items seized last month included 40 bottles of aspirin tablets, 129 bottles of cod-liver oil, and 52 tubes of corpus luteum tablets, all charged as below the claimed standards; 137 ampuls of phenobarbital sodium, 168 packages of cotton swab applicators, 2,605 packages of gauze bandages, 321 packages of absorbent cotton, and 587 sutures, all unsterile; 820 gross of defective mechanical prophylactics; 248 bottles of a "syrup of tar with extract of cod liver and menthol," found low in the vitamins of cod-liver oil.

These five patent medicines were seized on the charge that they bore false and fraudulent therapeutic claims in their labeling: 56 bottles of Dr. Eells' Vitalizing Blood Purifier, 74 bottles of Enrich, 45 bottles of McMillan's Nomoppin, 33 jars of Oxylin Greaseless Ointment, and 26 packages of Wyant's Eye-Bright.

Diet Relieves Obesity with Sugar in Urine.—A condition in which obesity is the principal abnormality and hyperglycemia excess of sugar in the blood) is secondary, is given a new interpretation by L. H. Newburgh, M.D., and Jerome W. Conn, M.D., Ann Arbor, Mich.

Their study of thirty-five obese, middle-aged persons with glycosuria—sugar in the urine—is reported in *The Journal of the American Medical Association* for January 7.

The study suggests that the occurrence of hyperglycemia and glycosuria in such persons depends on the excessive accumulation of fat in the liver, with a resulting impairment in its capacity to lay down glycogen (liver sugar) at the normally rapid rate.

After the weight of these patients has been reduced to normal by simple underfeeding, they remain without sugar in the urine, do not have an excess of sugar in the blood when they are placed on maintenance diets containing 10 ounces of carbohydrate and exhibit a normal tolerance to sugar.

Recurrence of the obesity is capable of reproducing the hyperglycemia and the delayed utilization of sugar. Subsequent reduction of weight again corrects the disturbance in the metabolism of carbohydrate.

VITAMIN D REQUIREMENTS

Journal of the American Medical Association, August 20th, 1938, Vol. 111: 703

> ". . . Tentatively the vitamin D requirement of the infant fed cow's milk may be stated as between 300 and 400 units daily, these amounts having been shown to be efficient in prophylaxis of rickets, in producing ample retention of calcium and phosphorus and in permitting excellent skeletal growth and dentition. This requirement is stated in terms of vitamin D of no greater concentration than is found in average high grade cod liver oil."
>
> ". . . 300 to 400 units daily as cod liver oil or as milk containing 400 units to the quart allows sufficient vitamin D to prevent rickets of clinical significance in both full term and prematurely born infants."

The above excerpts were taken from the article entitled, "The Human Requirement of Vitamin D," by Doctors P. C. Jeans and Genevieve Stearns of Iowa City.

For a very fine discussion on vitamin D requirements we recommend the reading of this entire article.

Special Morning Milk contains 500 units of vitamin D to the reconstituted quart (16 fl. oz. Special Morning Milk and 16 fl. oz. water). The vitamin D added to Special Morning Milk is obtained from the natural source—cod liver oil. However, there is no cod liver oil taste in the milk.

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Bequest Forms: Unto the California Medical Association*

FORM OF CLAUSE OF WILL PROVIDING FOR CASH BEQUEST

I hereby give and bequeath unto Trustees Of The California Medical Association, a nonprofit corporation of California, the sum of $——— to be known as the ——— Gift, to be used and expended by said corporation for scientific, educational, or hospital purposes.

* * *

FORM OF CLAUSE OF WILL PROVIDING FOR CASH BEQUEST

I give and bequeath unto Trustees Of The California Medical Association, a nonprofit corporation of California, the sum of $———, to be held as a fund, to be known as the [here insert name desired] Fund, the principal whereof shall from time to time be invested to the best advantage compatible with safety, and the income whereof shall be used and applied for scientific, educational, or hospital purposes.

* * *

FORM OF CLAUSE OF WILL PROVIDING FOR BEQUEST OF PERSONAL PROPERTY

I give and bequeath unto Trustees Of The California Medical Association, a nonprofit corporation of California [here describe the property], the same, or the proceeds thereof, to be held as a perpetual fund, to be known as the [here insert name desired] Fund, the income whereof shall be used and applied for scientific, educational, or hospital purposes. The said corporation shall have the power to sell said property and to invest and reinvest the proceeds arising from the sale thereof from time to time as it may deem advisable for the purpose of producing as large an income as may be compatible with safety.

* * *

FORM OF CLAUSE OF WILL PROVIDING FOR DEVISE OF REAL PROPERTY

I give and devise unto Trustees Of The California Medical Association, a nonprofit corporation of California, to aid and further its scientific, educational, and hospital purposes, and to be known as the ——— Gift, the following described real property situate in the County of ———, State of California, and more particularly described as follows, to wit:

* * *

FORM OF CLAUSE OF WILL PROVIDING FOR DEVISE OF REAL PROPERTY

I give and devise unto Trustees Of The California Medical Association, a nonprofit corporation of California [here describe the property], the same, or the proceeds thereof, to be held as a perpetual fund, to be known as the [here insert name desired] Fund, the income whereof shall be used for and applied to the support and maintenance of scientific, educational, or hospital purposes. The said corporation shall have the power to sell said property and to invest and reinvest the proceeds arising from the sale thereof from time to time as it may deem advisable for the purpose of producing as large an income as may be compatible with safety.

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* These Bequest Forms were discussed editorially in CALIFORNIA AND WESTERN MEDICINE, for March, 1936, p. 145, and June, 1936, p. 460.

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10 ozs. Water	12 ozs. Water
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Carb.	6.1%	6.5%
Prot.	2.0%	1.5%
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CALIFORNIA
AND
WESTERN MEDICINE

OFFICIAL JOURNAL OF THE CALIFORNIA MEDICAL ASSOCIATION

VOL. 50 APRIL, 1939 NO. 4

California and Western Medicine
Owned and Published by the
CALIFORNIA MEDICAL ASSOCIATION
Four Fifty Sutter, Room 2004, San Francisco, Phone DOuglas 0062

Address editorial, business and advertising communications to Dr. George H. Kress as per address above.

EDITOR . . . . GEORGE H. KRESS

Advertisements.—The Journal is published on the seventh of the month. Advertising copy must be received not later than the fifteenth of the month preceding issue. Advertising rates will be sent on request.

BUSINESS MANAGER . . . . . GEORGE H. KRESS
Advertising Representative for Northern California
L. J. FLYNN, 544 Market Street, San Francisco (DOuglas 0577)

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Subscription prices, $5 ($6 for foreign countries); single copies, 50 cents.

Volumes begin with the first of January and the first of July. Subscriptions may commence at any time.

Change of Address.—Request for change of address should give both the old and the new address. No change in any address on the mailing list will be made until such change is requested by county secretaries or by the member concerned.

Responsibility for Statements and Conclusions in Original Articles.—Authors are responsible for all statements, conclusions and methods of presenting their subjects. These may or may not be in harmony with the views of the editorial staff. It is aimed to permit authors to have as wide latitude as the general policy of the Journal and the demands on its space may permit. The right to reduce or reject any article is always reserved.

Contributions—Exclusive Publication.—Articles are accepted for publication on condition that they are contributed solely to this Journal. New copy must be sent to the editorial office not later than the fifteenth day of the month preceding the date of publication.

Contributions—Length of Articles: Extra Costs.—Original articles should not exceed three and one-half pages in length. Authors who wish articles of greater length printed must pay extra costs involved. Illustrations in excess of amount allowed by the Council are also extra.

Leaflet Regarding Rules of Publication.—CALIFORNIA AND WESTERN MEDICINE has prepared a leaflet explaining its rules regarding publication. This leaflet gives suggestions on the preparation of manuscripts and of illustrations. It is suggested that contributors to this Journal write to its office requesting a copy of this leaflet.

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EDITORIALS[†]

CALIFORNIA MEDICAL ASSOCIATION ANNUAL SESSION: DEL MONTE MAY 1–4, 1939

Pre-Convention Bulletin and Program Supplement.—The Annual Session Program and Pre-Convention Supplement to this April issue of CALIFORNIA AND WESTERN MEDICINE presents a most interesting word picture, in part, of what may be expected when the doctors of medicine who compose the guild of licensed physicians in this State convene in Del Monte.

The scheduled sessions really begin on Sunday, and California Medical Association members who can do so should avail themselves of the opportunity to gather at the inviting Hotel Del Monte, to attend some of the informal meetings of the day preceding the regular session that begins on Monday, May 1.

In recent issues of the OFFICIAL JOURNAL considerable information concerning these forthcoming gatherings has been outlined, and the Program Supplement is now called to the attention of all Association members because of details contained therein. Even though you know that it may not be possible for you to attend, it will be worth your while to scan the pages of the Supplement, and note for yourself the nature of the scientific problems which several scores of colleagues have been studying, and concerning which they will give their tentative or other comments in the section meetings at Del Monte.

* * *

Pre-Convention Bulletin.—No less worthy of perusal are the reports, in the Pre-Convention Bulletin section, of officers and committees. These fellow members, the duly elected representatives of the State Association and its component societies, are the colleagues upon whose shoulders have fallen not only mantels of honor, but also burdens of heavy labor. For the profession they love, they have given of themselves the best service of which they are capable. Withal, they are most modest in speaking of both time and effort freely spent, their accounts being little more than epitomes of end results attained. Glance through the pages of the Pre-Convention Bulletin and observe the wide range of activities within the Association.

[†] Editorials on subjects of scientific and clinical interest, contributed by members of the California Medical Association, are printed in the Editorial Comment column which follows.

Other Reasons for Attending the Annual Session.—This year, it is especially desirable that there be a free interchange of opinion on some of the important issues challenging the medical profession. Certain proposed laws, now before the California Legislature, will, if enacted, change the whole background and character of medical practice in California. Why not, then, journey to Del Monte and exchange views with your fellows on these problems, and then acquaint your constituted representatives with your understanding of the issues involved? It will be as good, yes, better than an ordinary vacation; for, in fact, if certain proposed statutes are sanctioned by the Legislature, there may be, for some time to come, for many members of the profession fewer, if any, vacations. So, if at all possible, join with the others in this migration to one of the most delightful corners of California's garden world, and be present at Del Monte for at least one or more of the wonderful days.

"C. P. S."—CALIFORNIA PHYSICIANS' SERVICE*

Real Progress Has Been Made.—During the last several months, organized medicine in California has been making pioneer progress in a State-wide plan by means of which citizens belonging to certain lower income groups will be able in future, through periodic payments, to secure for themselves assurance of medical service and hospitalization that will speedily eliminate the justifiable fear so often associated with the matter of possible and burdensome costs which confront one in an experience with unforeseen and unpredictable illness. It is gratifying, therefore, to know that the response to the letters, inviting all doctors of medicine who are licensed to practice in California to register under this voluntary plan of California Physicians' Service, has been so generously prompt.

That, however, is not enough. It is desirable, more, it is important, that every doctor of medicine in the State should personally align himself with this movement. Wherefore, keep in mind that your colleagues, who have accepted the responsibility of serving as members of the Board of Trustees of the California Physicians' Service, have been giving hours and days of their time and best thought in the effort to set this C. P. S. in efficient operation. They are worthy of wholehearted coöperation. Fail not to send in your registration letter.

* * *

To Physicians Who Have Failed to Register. If, then, you who read these lines are among those who have not yet sent in your registration blank, may we not urge you to do so today!

If, however, you have, perchance, misplaced the letter that was mailed to you, write at once to California Physicians' Service, 602 Mills Building, 220 Montgomery Street, San Francisco, and request another blank. Then sign and remail it at once!

PROPOSED STATUTES: CALIFORNIA LEGISLATURE

Biennial Sessions Have Not Lessened Proposed Legislation.—When, some years ago, the California Legislature changed its sessions from an annual to the biennial type, one of the hopes expressed was that proposed legislation submitted in the biennial gatherings would be lesser in quantity and better in quality. In the March issue of CALIFORNIA AND WESTERN MEDICINE, however, on pages 172 and 213, attention was called to the fact that more than four thousand (4,000) laws had been submitted by the State Senators and Assemblymen now in session at Sacramento—an all-time, so it is said, high!

The many proposed statutes having relation to public health and medical practice were indicated in the comments given on pages 213–218, as taken from a preliminary draft made by the California Medical Association Committee on Legislation and Public Policy. That list should be inspected.

* * *

Extended Comment on Proposed Laws Not Possible.—To attempt to give extended comment on these many legislative endeavors, therefore, would require far more space than the OFFICIAL JOURNAL is able to allocate. It is suggested, however, that members who are interested may find additional and interesting comment in the Press Clippings columns of the News Department of each issue of CALIFORNIA AND WESTERN MEDICINE.

* * *

California Medical Association's Legislative Record in Former Years.—It is an interesting fact that, in spite of general opinion to the contrary, it has so happened—not only for this year, but for decade after decade, and from the time the first medical practice act was brought into being—that the medical profession of California, through its organized units, has presented to the State's statute makers for consideration comparatively few laws. It is also true that, although the medical profession itself proposed and led in the struggle to protect the health and lives of citizens, through laws that brought into being a medical practice act, in which decent standards of education and training for practitioners of the healing were demanded —and of a State Board of Health—with function to supervise the administration of sanitary and other statutes designed to promote the conservation of health and life—it may be stated without fear of contradiction that its legislative activities have otherwise been called into action only on occasions when onslaughts, devious or in the open, were being made against those statutory enactments which experience, in the different commonwealths of the Union, had proved to be necessary implements if the health and happiness of the states' citizens were to be properly safeguarded.

* * *

On Several Measures Now Before the Legislature.—At Sacramento, at the present time, animated discussions recurrently flare up when hearings, such as the following, are held on measures having to do with proposed legislation:

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* For other items, see page 289.

Registration of nurses under a separate board, instead of under a bureau supervised by the State Board of Health;

Opening county hospitals to all citizens, be they indigent or not, and making provision for the admission of part and full-pay patients, as well as of indigent and near-indigent (medically indigent) groups;

On whether opticians, who grind lenses, and who practically came into vocational being under the tutelage of doctors of medicine who were specialists in diseases of the eye, should now come under the sole supervision of the State Board of Optometrists, instead of maintaining an independent relationship that will permit them to serve ophthalmologists without the introduction of optometric middlemen;

On certain proposed laws, submitted with the approval of the State Board of Medical Examiners, whereby qualifications of citizenship and proper certification of professional training would be necessary before California licensure could be granted; and last, but by no means least,

On whether the great State of California, with its six million citizens, a geographical domain of imperial range and economic, cultural and other characteristics that have set it apart as a conspicuous star in the galaxy of States of the Union, should now become the guinea pig for a compulsory health law, thrust forward, not by scientific medicine—as betokened in the representative body known as the California Medical Association—but by a strenuous group of lay propagandists who, with argument often fallacious, specious or otherwise faulty, have for the moment seemingly misled many well- and right-meaning citizens.

* * *

Legislature Will Continue in Session Through April and May.—Suffice it to say, that in the months of April and May, and until the time on which the California Legislature adjourns, members of the medical profession of California, both for themselves and for the public, will do well, each day, to scan the papers for press dispatches emanating from Sacramento, in order to be more alert and responsive to action that may be indicated.

* * *

No Need for Revolutionary Changes at This Time.—This year of years, officers and committees on legislation and public policy of component county medical societies have indeed a serious responsibility, both to their colleagues and other fellow citizens.

When, therefore, the call for united action comes, let there be no faltering. Everywhere, whether in urban or rural communities, the response must be one and the same. The issue at stake is the perpetuation of proved methods of medical advancement and service, by evolutionary methods having the support of the one group of citizens who know most about medical practice and needs—the doctors of medicine in California—whose services to the State in the past may be taken as the best indication that they will not be found wanting in the days to come. The organized medical profession of California has espoused a voluntary system of health service. That being the case, revolutionary plans of an experimental nature may well wait before being translated into legal enactments.

CALIFORNIA MEDICAL ASSOCIATION ROSTER: A NECESSARY IMPLEMENT IN MEDICAL ORGANIZATION

Rosters of Membership Are of Real Service and Value.—Membership rosters of an organization for many persons may have little reading allure; but such printed compilations are often useful adjuncts to efficient organization. And organization—militant organization—is much, very much needed by the medical profession at the present time.

Today in the press, coming from all kinds of sources, will be found communications without end, in which bias, prejudice, ignorance, and other elements may without difficulty be discerned. Why? How come?

* * *

Why Is Medicine Misunderstood?—Perhaps because members of the medical profession, as in years gone by, carrying on in altruistic manner, and giving generous service to all, without regard to class or economic status, and loyal to the code as handed down by Hippocrates, have been slow to discern radical social and economic changes rapidly going on. During many years, physicians have been giving to the world, without remuneration or request for any kind of reward, the many discoveries that, little by little, have permitted civilized man to subdue diseases which formerly scourged, and more than decimated, the human race—so that today the life span of man on earth has been increased, not by single years, but by several decades. These idealistic medical men have failed adequately to recognize the revolution that recent industrial mechanization and other influences have brought about, not only in modes of physical living, but in the mental outlook of mankind.

In other words, it may be said, perhaps, that medicine is misunderstood because physicians, carrying on in daily service, in that peculiar personal relationship of individual patient to individual doctor—so essential for the production of the best type of work in both the science and art of medicine—have neglected to note how, in almost all other lines of human activity, groups have become increasingly interdependent, the one upon another. And part of the misunderstanding may arise, likewise, because of failure by physicians to call the attention of laymen to the fact that healing-art practice is something very different from activities such as are evidenced in manufacturing or industrial plants; and that the coördination that makes for better mass output in such establishments would, in medical practice, lead only to disaster, both for the people to be served and for the profession whose members would be called upon to render the service.

* * *

Rosters Should Be Preserved for Future Reference.—A Membership Roster, therefore, is of real use, since it permits each physician to understand better the background of his local and state organization. Take the time to scan some of its pages. Also, keep the copy on your book shelf for use in the months to come. You may find such a roster a most handy aid on more occasions than one.

Other State Association and Component County Society News.—Additional news concerning the activities and work of the California Medical Association and its component county medical societies is printed in this issue, commencing on page 285.

EDITORIAL COMMENT†

ZINC INSULIN CRYSTALS (CRYSTALLINE INSULIN)

An analysis of the comparative efficacy of unmodified, or regular insulin, protamin-zinc insulin and zinc insulin crystals, by a number of investigators interested in the treatment of diabetes mellitus, has led to the conclusion that zinc insulin crystals (in solution) has a definite place in the treatment of diabetes. Moreover, it has been shown that in certain cases therapeutic results with zinc insulin crystals have been more satisfactory than those obtained with unmodified insulin or with protamin-zinc insulin.

A recent study of the relative effects of regular insulin and the so-called long-acting insulins among a group of patients with uncomplicated diabetes, carried out at the Diabetic Clinic of the University of California Medical Center, culminated in the following results:

1. There was a definite reduction in the *average total daily dosage* among all patients who were changed from regular insulin to either of the long-acting insulins (protamin-zinc insulin or zinc insulin crystals). This reduction in dosage was greatest among those patients with severe or moderately severe diabetes, who were transferred to zinc insulin crystals. In patients with mild diabetes the reduction in dosage was not great, and was about the same for both types of long-acting insulins.

2. A reduction in the *average number of daily injections* also followed the change to long-acting insulins from regular insulin. This reduction in dosage was about the same for those patients who received either protamin-zinc insulin or zinc insulin crystals, except in those patients with moderately severe diabetes. In this latter group the reduction in the number of injections per day was greater, after changing from regular insulin to zinc insulin crystals, than was possible to accomplish by the use of protamin-zinc insulin.

3. *Better control of diabetes* followed the use of insulins with prolonged action. This was most outstanding among those patients who were transferred to zinc insulin crystals. Interestingly enough, improvement in the status of the diabetes was most pronounced in those patients with severe diabetes.

4. *No allergic reactions* were encountered in any of the patients receiving zinc insulin crystals.

Whereas the explanation for the prolonged hypoglycemic effect of protamin-zinc insulin seems to have been adequately made by its various proponents, no satisfactory rationale for this property of zinc insulin crystals has been offered until recently.

Lately, however, we have had the opportunity of discussing this matter with Doctor Sahyun of Detroit, who is responsible for the introduction of zinc insulin crystals. His opinions regarding the properties of this new therapeutic agent have shed considerable light on the subject.

According to Sahyun, zinc insulin crystals exhibit the reactions of a true protein and represent the actual hormone (insulin). Zinc insulin crystals possess an iso-electric point of about p^H 5.3, and are separated by the usual protein precipitants, such as tungstic acid, molybdic acid, etc. They are thrown out of solution by high concentrations of such salts as sodium chlorid and ammonium sulfate, are hydrolyzable in acid or alkali, and are attacked by proteolytic enzymes. Upon hydrolysis they yield the following amino-acids: cystin, histidin, lysin, tyrosin, leucin, arginin, prolin, phenylalanin, and glutamic acid.

Zinc insulin crystals occur in a rather fine form, seldom exceeding 0.01 millimeters in diameter. They do not possess a true melting point, but turn brown at about 210 degrees centigrade and melt with decomposition at about 225 degrees centigrade. The molecular weight has been estimated at about 35,000. A solution of zinc insulin crystals is levorotatory, but its specific rotation is dependent to a large extent not only upon the p^H of the solution, but also on the acid or alkali used for dissolving the insulin.

Zinc is necessary for the crystallization of insulin; it also acts as a protective agent, stabilizing its potency (physiologic activity). It was originally thought the zinc in crystalline insulin was responsible for its prolonged action. Sahyun feels, however, that this is not the case. He states that the zinc content in crystalline insulin within limits up to one milligram per 1,000 units does not prolong its action. He is also of the opinion that the presence of zinc in a concentration of one milligram per 1,000 units assures no greater stability of solution than the product now on the market, which contains only 0.2 to 0.4 milligram of zinc per 1,000 units (a requirement of the Insulin Committee in Toronto, Canada). However, it has been found possible to increase the prolonged action of crystalline insulin by the addition of zinc, but in quantities of 8 to 9 milligrams per 1,000 units.

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† This department of CALIFORNIA AND WESTERN MEDICINE presents editorial comments by contributing members on items of medical progress, science and practice, and on topics from recent medical books or journals. An invitation is extended to all members of the California Medical Association to submit brief editorial discussions suitable for publication in this department. No presentation should be over five hundred words in length.

Sahyun feels that solution zinc insulin crystals owe their prolonged action to a greater insolubility on the alkaline side of its iso-electric point than that possessed by regular insulin. Consequently, the prolonged hypoglycemic action is due to a delay in absorption and eventual utilization of the insulin (injected at a p^H of 3.0) by the body during its changes from an acid p^H to the slightly alkaline p^H of the tissue fluids.

Of importance is the fact that a pure crystalline product is available, which has a duration of action of at least twelve to fourteen hours. This duration may be considered to be more physiological than the prolonged hypoglycemic action of protamin-zinc insulin, whose tendency to an accumulative action in certain patients is undesirable. Furthermore, in the absence of extraneous proteins, the allergic hazard is confined to an inconsequential number of individuals who may be sensitive to the insulin molecule.

384 Post Street.

R. D. FRIEDLANDER,
H. CLARE SHEPARDSON,
San Francisco.

NAZI IDEOLOGY AND MEDICAL RESEARCH

The amount of physiologic research now being done in Nazi Germany is 33 per cent below that produced after the World War during the reign of democracy. This slump in internal German medical research, however, is more than counterbalanced by the 50 per cent increase in the productiveness of German-speaking physiologists living outside the Third Reich. These conclusions, currently reported by a leading American statistician[1] are based on a linguistic analysis of the papers presented before the thirteenth International Congress of Physiology (Boston, 1929) and the sixteenth Congress held last summer at Zurich.

English, French, German, and Italian are the official languages of these congresses. Nine years ago, 106 of the papers before the Boston meeting were in German. Of these, sixty-one (58 per cent) reported researches done in German laboratories, while forty-five (42 per cent) represented work done by the German-language group in Hungary (10), Czechoslovakia (9), Russia (9), Switzerland (6), Austria (5), Netherlands (4), and Esthonia (2). At the Zurich Congress last summer only 40 per cent of the German papers represented national contributions to medical science, while 60 per cent reported work done by German-speaking scientists living in Switzerland (21), Netherlands (13), Czechoslovakia (10), Hungary (9), Sweden (6), Austria (4), Palestine (3), Turkey (3), Poland (2), Italy (2), Belgium (1), and Esthonia (1). During the nine years, therefore, the relative amount of German physiologic research has decreased by one-third. Outside of Germany, the German-language group has increased its relative research output over 50 per cent.

The same statistics show that French and Italian physiologic research has not declined during the nine years. American and English physiologic researches have increased. If German medical research continues to decline at the same rate, the Third Reich will fall behind Czechoslovakia by 1970, and to the level of Palestine by the end of the century.

Totalitarian ideology *per se* is apparently not detrimental to medical progress, as shown by the sustained output from Fascist Italy. There is, evidently, some factor in Nazi ideology, however, that is detrimental to initiative, originality and intellectual fertility in medical science. In the long run, this handicap to scientific progress may be a dear price for Nazi Germany to pay for its growing military efficiency.

P. O. Box 51.

W. H. MANWARING,
Stanford University.

Blindness Problems.—The International Association for Prevention of Blindness, which maintains a secretariat in Paris, will hold its next annual meeting in London on Wednesday, April 19, 1939.

The principal topic for discussion will be "The Application of the Crede Method for Prevention of Blindness in Various Countries." This refers to the use of a prophylactic solution in the eyes of infants at birth in order to prevent ophthalmia neonatorum, commonly known as "babies' sore eyes."

In the United States there has been a 75 per cent reduction during the past thirty years in the number of cases of blindness from ophthalmia neonatorum. How this was accomplished will be related at the international meeting by Dr. Conrad Berens of New York City, a member of the board of directors of the National Society for the Prevention of Blindness, 50 West Fiftieth Street, New York.

America will be represented also by Dr. Harry S. Gradle of Chicago, vice-president of the Illinois Society for the Prevention of Blindness, and Dr. Park Lewis of Buffalo, vice-president of both the International Association and the American National Society.

Fractures of Arm Just Above Elbow Are Most Difficult to Treat.—The most difficult fractures to treat are those of the arm, just above the elbow, George J. Garceau, M.D., Indianapolis, points out in *The Journal of the American Medical Association* for February 18.

The physician should consult with an orthopedic or bone surgeon in difficult cases of such fractures, Doctor Garceau says, basing his paper on an analysis of 133 fractures of this type. These fractures occur most frequently in children. Immediate reduction (alinement) of the fracture promises good results. Delay makes reduction more difficult because the soft tissues become hard and the muscles and tendons contract. With delay it may become necessary to open the elbow and reduce the fracture. This slows up the recovery.

When only one of the eminences is loose from the rest of the bone it is usually necessary to reduce it by open operation.

---

[1] "M. D.," Science, 88:594 (Dec. 23), 1938.

ORIGINAL ARTICLES

URINARY TRACT INFECTIONS*

FROM A GENERAL PRACTICE STANDPOINT

By H. C. Bumpus, Jr., M.D.
Pasadena

PART I

CHANGES in the treatment of urinary-tract infections have occurred with such rapidity during the past few years that urologists have found it difficult accurately to evaluate the various forms of therapy before they become obsolete. During this time the general practitioner has been literally swamped by the various drug houses with an apparently never-ending series of new urinary antiseptics; each one, not only claimed to be more efficient than its predecessor, but invariably proved to be more expensive.

The scope of the national advertising with which each of these new panaceas was launched invariably exceeded that of its predecessor, until the price of the product became so excessive as to arouse protest from both physician and patient. This was usually met with the assurance that their efficiency was in direct proportion to their cost: after all, first-class articles or services are usually expensive, and why should medicines prove any exception to that well-established rule? The possibility that a medicine might receive universal adoption on its merits alone seemed to occur to no one. It was taken for granted that a new urinary germicide, upon its presentation to the profession, would require as elaborate a build-up as that accorded the latest automobile model or movie star. That such a build-up might as frequently serve to hide the shortcomings of the product occurred to some of the more skeptical ones.

Such was the case when the efficacy as a urinary antiseptic of certain of the much-publicized azo dyes was demonstrated by the circulation of drawings and photographs of test-tubes and petre dishes. In the controlled test-tubes most of the noxious organisms commonly found in urine were seen to grow in great abundance, while in the culture media to which even minute amounts of the advertised dye were added growth was inhibited. Such an ocular proof of the antiseptic value of the product as that seemed beyond refutation; yet a graduate student named James Gillespie, presumably from Missouri, repeated the tests as described in the advertising matter, and in his thesis wrote: "Antisepsis in urine is quite different from antisepsis in water. Compounds which exert a striking bactericidal action in water may have this power greatly diminished or lost in urine. This well-recognized fact has excluded many drugs from the list of valuable urinary antiseptics. The value of every drug used for urinary antisepsis ought to be questioned until this antiseptic strength in urine can be experimentally demonstrated. Compounds, the antiseptic power of which is due to acid or basic properties, would become inert in the urine due to the buffer action of urinary salts. Other compounds containing silver become inert in the urine because silver is precipitated by the chlorids."

To demonstrate the correctness of these statements, he added a few drops of urine as well as the azo dyes to his culture media; and upon incubation the profusion of growth was as great in the tubes to which the dye had been added as in the controls. In the presence of urine, the much advertised germicidal action of these dyes for urinary infections was completely neutralized.

The beginning of this period of the active commercialization of urinary antiseptics dates roughly from the presentation of the first perfect germicide in the form of mercurochrome, which you will recall started as an intravenous drug, and after a rather colorful life has found its place as a popular substitute for iodin. The career of hexylresorcinol, alias capricol, has been similar. Starting as a urinary antiseptic par excellence at ten cents a capsule, it is now advertised as a tooth paste. It was during this period that the commercial laundries benefited, I believe, even more than our patients; for the amount of underwear that was stained by pyridium, serenium, and picrocain must have kept many an individual off the PWA rolls. In the meantime, that reliable friend of our early practice, urotropin, having changed its surname from hexamethynamin to methenamin had, like the aging wife, been abandoned and divorced while we philandered with these gayer and more colorful products. Like most such alliances, the younger consort proved fickle and inefficient, and we were then urged to become drug nihilists and combat our enemies in the urinary tract by diet, the ingestion of which, because of its high fat content, seemed impossible for any but an Eskimo, but which those in the temperate zone were expected to partake of for at least a fortnight if any lasting results were to be obtained. Yet the results of the ketogenic diet proved so illusory, except under the most rigid supervision, that it was soon abandoned, and the profession was assured that a similar but surer effect could be obtained by the administration of mandelic acid. Any of the profession who essays to take his own medicine in the form of the elixirs or syrups, in which form it is commonly dispensed, must agree that the ketogenic diet, difficult as it was to ingest, was preferable, and that the presence of a few pus cells and bacilli in the urine are much less disturbing to bodily comfort.

At the present time we are in the sulfanilamid stage. This drug seems destined to be the exception that proves the rule. It is cheap and, instead of being suddenly thrust upon us, we find that it has proved its usefulness gradually over a long period of time. Gelmo, working on the chemistry of azo dyes, was the first to mention this drug in 1908, while Dormack, director of the experimental pathologic laboratory of Elberfeld, Germany, was the first, in 1935, to point out its therapeutic possibilities.

SOME FUNDAMENTAL PRINCIPLES OF UROLOGIC PRACTICE

However, before discussing the efficacy of these various urinary antiseptics, it would seem pertinent to review briefly the diseases for which they are intended, and discuss some of the fundamental principles of urologic practice as they apply to infections of the urinary tract.

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* Read before the Santa Barbara County Medical Society, December 9, 1938.

Someone has said that the chief function of the urologist is to insure the adequate and constant drainage of the urinary tract. This is certainly a basic principle and, with very few exceptions, no method of therapy will long prove efficient if the passage of urine from the renal papellae to the urethral meatus is in any way obstructed. Probably nowhere is this so well clinically demonstrated as in the case of pyelitis of pregnancy. Here, for some reason, upon the exact cause of which the authorities differ, there occurs a dilatation of the upper urinary tract associated with urinary stasis. If infection is added, the clinical picture may become very grave. In the majority of cases such infection occurs on the right side, and the institution of ureteral catheter drainage will, in a few hours, by emptying the renal pelvis, return the highest of temperatures to normal with complete abatement of the most extreme degrees of prostration. In most cases drainage is all that is required. Without such urinary drainage all germicides are of little value although, administered in conjunction with drainage, they prove beneficial. We must consider, therefore, adequate drainage as imperative before any form of germicide can be expected to prove effective.

QUANTITY OF URINE OUTPUT

Certainly the next most important factor in all cases of urinary infection is the copious output of urine. If this is not possible by oral administration it should be given by subcutaneous or intravenous means either in the form of normal saline or five per cent glucose. In recent years the intravenous method has largely replaced the subcutaneous due, I think, to the fact that the subcutaneous method, when it first came into vogue, employed large needles resembling trocars, and the fluid was allowed to accumulate in considerable amounts in the subcutaneous tissues to the great discomfort of the patient. If the subcutaneous administration of fiuids is given with multiple small needles, it may be run for days at a time with little discomfort and to great advantage. By this method, moreover, the possibility of embarrassing a faulty cardiac musculature is avoided, a risk that many believe to be associated with the intravenous method of administration. Certainly, any patient with an acute urinary infection should excrete in excess of 2,500 centimeters of urine daily; if the surrounding room temperature is high this will be difficult to obtain by oral administration. Furthermore, the ingestion of too great an amount of fluid by mouth upsets the gastro-intestinal tract, and the patient loses the benefits of adequate digestion and may develop so-called water intoxication, as described by Rowntree in his studies of the effect of pituitrin in cases of diabetes insipidus, with resultant serious pathologic changes in the nervous system.

Keyes has written that "the diagnosis of renal infection depends rather upon the arousing of the suspicions of the medical examiner to the fact that the patient may have a renal infection than upon anything else. Once renal infection is suspected, it can readily enough be diagnosed."

The reason for our neglect to more frequently recognized renal infection is due, I think, to the fact that we have come to associate pyuria with renal infection; the idea that one may exist without the other is seldom entertained, and yet clinical experience and painstaking study have demonstrated repeatedly that such may be the case. The fact that a carefully conducted physical examination frequently fails to indicate an involved kidney is also unquestionably responsible for our too frequent failure to have our suspicions aroused.

Although there are exceptions which, because of their rarity, may be disregarded, it is accurate to state that in the vast majority of cases renal infections occur either by the hematogenous or ascending route, and are apt to be associated with some form of urinary stasis either permanent or temporary.

RÔLE OF BACTERIA

A great variety of bacteria have been isolated, and reports vary as to the incidence of certain types. Thus, if the investigation includes many cases of pyelitis in children or during pregnancy, the incidence of Escherich's coli will be overwhelming; if such an investigation should be made in an institution like the Mayo Clinic, the colon organism will be far from the predominant one, though still in the majority.

Formerly it was customary, once having excluded the possibility of tuberculosis, to be satisfied with knowing merely if the infecting organism was a bacillus or a coccus. So rapidly has therapy progressed that today one can hardly be said to be carrying on the best type of attack unless he knows the organisms which he is attacking. At first this might seem to demand a bacteriological knowledge and equipment beyond the reach of most practitioners; but such is not the case, for urinary sediment stained by Gram's method generally proves sufficient, and only the more unusual types of bacteria need the assistance of a bacteriologist to correctly name them. In fact, the stained sediment is not infrequently more accurate than cultures, especially in the case of renal infections, as is shown by a recent study of Buchtel.

That bacteria can reach the kidney by the blood stream is self-evident, but fortunately few survive long enough to make the journey, and of those that do, the endothelial surfaces of the kidney tissues serve rapidly to annihilate the vast majority. The best clinical example of this is probably the so-called urethral chill following instrumentation, with a rapid rise of temperature to extreme heights associated with prostration of the patient, to be followed the next day by his discharge from the hospital apparently in the best of health. More frequent cases of hematogenous infection are those of the coccal type, which come from boils and carbuncles and which, either because of their increased virulence or repeated attacks, manage to become established in the renal parenchyma, and not infrequently lead to perinephritic abscess or carbuncle of the kidney. Closely associated with this group are the cases of coccal infection arriving from the upper respiratory tract during the course of acute respiratory infection. In these cases the urine excretion fails to show any pyuria, but if during the early course of the infection the urine specimen is centrifuged for a prolonged period of time and carefully stained, the presence of cocci will be demonstrable. Their presence will explain the fever and elevated pulse, which are usually out of proportion to the severity of the respiratory involvement. In such cases a careful physical examination will generally elicit a point of tenderness to palpation at the costomuscular angle, a finding which will leave the diagnosis beyond question. There are few conditions in which it is so difficult to correlate the clinical picture, the urinary findings, and the pathological conditions. The pathologist seldom sees kidneys of this type, for, fortunately, the condition is rarely fatal; and if it is, the pathologic changes have progressed far beyond those that were present at the onset of the condition. However, the numerous renal scars seen in the routine examination of autopsy materially attest to the accuracy of our clinical deductions.

Because the infection is principally in the cortex of the kidney, the urine does not contain any cellular elements, and investigation by intravenous urography will usually prove negative, as the infection does not produce abnormalities discoverable by these methods. Of considerable clinical importance is the regular early development of perinephritis, which produces the tenderness so characteristically found in the costomuscular angle.

With this group must be included the cases of pyelonephritis which are the result of focal infection. While the relationship between an abscessed tooth, infected tonsil, cervix or prostate is not as easily demonstrated either clinically or experimentally, the best opinion today seems to favor such a relationship. It may be possible as our knowledge advances we shall discover that these distant foci, instead of supplying the actual organisms that infect the kidney, produce a toxin which, by its chemical affinity for renal tissues, makes possible the continued growth of the infection either by neutralizing the natural immune processes, or so affecting the involved tissue as to make the site favorable for growth. Certainly, a careful review of experimental work along this line points in that direction.

(To be continued)

TISSUE CHANGES IN CHRONIC INTOXICATION OF BARBITALS*

By T. L. Schulte, M.D.
San Francisco

TISSUE changes have been reported several times in patients following acute fatal poisoning by barbital and its derivatives,[1-10] the main pathological changes being in the central nervous system, liver, kidneys, and skin. Somewhat similar changes have also been reported in experimental animals.[11-15] However, no one thus far has reproduced, experimentally, the dermatitis observed clinically in sensitive individuals using these compounds. In connection with another study, it was observed in this laboratory that dogs anesthetized repeatedly with pentobarbital developed a macular papular exanthem, accompanied by depilation, cracking and oozing, and resembling the clinical picture of barbital dermatitis. In the hope that this phenomenon might be reproduced which would permit an experimental study of the clinical manifestations of barbital idiosyncrasy, the following experiments were performed to study the phenomenon in more detail. In brief, there were carried out long-continued administrations to dogs and white rats of various members of the barbital group and histological examinations for possible alterations in skin and other organs.

PENTOBARBITAL AND AMYTAL IN DOGS

Pentobarbital.

Fifteen young adult dogs, fourteen males and one female, were used, three of the males serving as controls. The animals were fed a diet of commercially prepared dog food and water, and kept in the regular animal quarters. Food was withdrawn twice weekly for eighteen to twenty-four hours, then an intraperitoneal injection was given of pentobarbital † (sodium ethyl (methyl-propyl carbinyl) barbiturate), 50 milligrams per kilogram body weight, dissolved in three cubic centimeters of distilled water. Narcosis resulted in from thirty seconds to ten minutes and lasted from ten to twelve hours.

Four dogs died of intestinal perforation and peritonitis, following injection. Histologic examination of these animals showed cloudy swelling of the liver, kidney, spleen, and heart muscle, with septic infarcts and areas of necrosis in which bacilli were present. It is doubtful if these changes had any relationship to the effects of the drug. The remaining seven males developed patchy areas of depilation, and a macular papular erythematous exanthem of the entire body except the head, neck and saddle, in an average time of fifty days.

When the skin rashes appeared, an attempt was made to determine in each dog whether a specific dermal sensitivity was present which could be demonstrated by patch tests. Accordingly, the hair was shaved from the dorsolateral thorax bilaterally over an area 10 by 10 centimeters. Gauze squares, 3 by 3 centimeters, were saturated with solutions and applied to the shaved areas for twenty-four hours as follows: (1) pentobarbital in distilled water; (2) dog urine, obtained by catheterization of the bladder one hour after narcosis developed; and (3) distilled water. However, the patch tests were all negative in all the animals in the thirteen tests made.

The female dog developed ataxia of the hind legs after fifty days, and by the fifty-fifth day was completely ataxic, and had urinary incontinence. Sensation was normal as far as could be determined. However, these signs completely disappeared after the one-hundredth day. This animal became pregnant during the course of the experiment and gave birth to six pups. These were sacrificed when they were two weeks old; histologic examination of the skin and vital organs showed them to be normal.

Injections were continued over a period of two hundred days, during which time about sixty injections in each dog were made, and then the dogs were sacrificed. Histologic examinations of the skin, liver, kidney, spleen, and heart muscle showed them to be normal, in spite of the gross changes in the skin. The control animals showed no skin lesions on gross and microscopic examinations, and the vital organs were similarly normal.

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* From the Department of Pharmacology, Stanford University School of Medicine, San Francisco.

† Supplied by Abbott Laboratories.

Amytal.

To test the specificity of this dermatitis for pentobarbital, two other dogs were similarly injected with sodium amytal* (sodium isoamylethylbarbiturate), using 50 milligrams per kilogram body weight, for 250 days, at which time they were sacrificed. Gross observation throughout, and histologic examination of the skin and vital organs at necropsy, revealed only normal tissues.

There was a possibility that the skin lesions observed in the first dogs were infectious, or resulted from the manner of handling the animals. Accordingly, an entirely fresh stock of dogs was obtained that had no contact with the previous animals. Three young adult male dogs were used, one being injected with physiologic saline solution (0.85 per cent NaCl) as a control. Otherwise the procedure was similar to the first group of dogs, *i. e.*, treatment with pentobarbital, 50 milligrams per kilogram, injected intraperitoneally twice weekly. The special feature of the fresh group was that the animals were placed separately in clean, padded cages after the injections, and, while narcotized, were protected from trauma to the skin as much as possible. These animals developed no skin lesions, and so were sacrificed on the seventy-fifth day. Histologic examinations of the skin and vital organs showed them to be normal. Therefore, it appeared probable that the dermatitis observed in the first group of dogs was due to some intercurrent infection, or to trauma from scratching during the recovery period.

Different Barbitals in White Rats.

However, a further test of the possibility of producing dermatitis was made in white rats. Forty-five young adult females were used, housed five to each cage, and fed Purina Dog Chow. One cage of these rats was used as a control and given injections of one cubic centimeter per kilogram of saline solution; a second cage of controls was injected with paraldehyd 1.2 cubic centimeter per kilogram, as a check on the effect of a nonbarbital depressant, and the rats of the other seven cages received various barbital derivatives, as follows: sodium barbital (sodium diethylmalonylurea) 150 milligrams per kilogram, sodium phenobarbital (sodium phenylethylmalonylurea) 70 milligrams per kilogram, sodium amytal (sodium isoamylethylbarbiturate)* 50 milligrams per kilogram, pentobarbital (sodium ethyl (methylpropyl carbinyl) barbiturate)† 30 milligrams per kilogram, phandorn (2, 4, 6 trioxy-s-cyclo-hexenyl-ethyl-pyrimidin) 120 milligrams per kilogram, pentothal† 80 milligrams per kilogram, and sedormid (allylisopropyl acetyl carbamid) 100 milligrams per kilogram. The injections were made subcutaneously, three times a week for thirteen weeks, at which time the rats were sacrificed and the organs examined histologically. No skin lesions appeared at any time after these barbitals. Histologically, normal skin, liver, kidney, spleen, and heart muscle were present in all the barbitalized rats and the controls.

COMMENT

The clinical reports in which necropsy revealed lesions in the liver and kidneys were in patients who had taken single massive doses of barbitals with suicidal intent. However, in some other similar cases no lesions in the liver and kidneys have been found. On the other hand, when a patient is sensitive to barbital or any of its derivatives, a single dose may be sufficient to cause a violent reaction. An exanthem following a single dose of phenobarbital has frequently been observed, and recently there has been reported thrombocytopenic purpura after the use of sedormid, apparently in sensitive patients.

The negative results in dogs and white rats obtained by me agree with those of Ravdin, Drobkin and Bothe,[11] Seevers and Tatum,[12] Holck and Kanan[13] and Swanson, Weaver and Chen.[15] The extensive dermatitis observed in the first group of dogs could not be reproduced under various conditions and, therefore, probably did not represent the same kind of dermal reaction seen clinically, but rather an intercurrent infection, or some manifestation of the experimental conditions other than the drug.

SUMMARY AND CONCLUSIONS

1. Skin lesions, manifested by depilation and a macular papular exanthem, were observed in seven dogs given pentobarbital intraperitoneally twice weekly for 205 days.
2. Repetition of this administration with pentobarbital and sodium amytal, in doses producing coma, did not furnish any histologic evidence of damage to the skin, liver, kidney, spleen, or heart muscle. Therefore, the skin lesions were probably due to scratching and purposeless movements made by the animals while emerging from narcosis, or they were infectious, since in other dogs placed separately into clean, padded cages following injection, no skin lesions developed.
3. Patch tests on these dogs, made with solutions of pentobarbital, urine and distilled water, gave negative results in thirteen experiments.
4. The following barbital derivatives or depressants injected subcutaneously into forty-five rats three times weekly over a period of ninety-one days, in doses producing coma, also caused no lesions in the skin, liver, kidneys, spleen and heart muscle, as determined by histologic examination: sodium barbital, sodium phenobarbital, sodium amytal, pentobarbital, phanodorn, pentothal, and sedormid. Control injections of paraldehyd and physiological saline solution also caused no pathological changes in the vital organs.

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VARICOSE VEINS IN PREGNANCY*

By A. M. McCausland, M.D.
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Discussion *by Nelson J. Howard, M.D., San Francisco; E. M. Lazard, M. D., Los Angeles; Lyle G. McNeile, M. D., Los Angeles.*

THIS is a preliminary report from the Los Angeles Maternity Service on the treatment of varicose veins complicating pregnancy.

This frequent complication predisposes to all degrees of invalidism throughout pregnancy as well as in later life. Their distressing symptoms and sequellae have been recognized for centuries. Unfortunately, as always, pregnant women, being the last to enjoy the benefits of medical and surgical advance, have been led to believe that varicose veins were part of the price of motherhood.

From the time of Ambrose Paré, in 1579, the injection treatment of varicose veins in pregnancy has been discouraged and condemned. The use of taping, bandages and elastic stockings was recommended, and afforded some temporary relief to the lower leg, but proved of little value in varicose veins of the vulva and upper thigh, where they are often extensive.

In 1931, Dr. H. O. McPheeters, in what was thought to be a daring article, urged the prophylactic injection treatment of varicose veins during pregnancy. This was based upon a series of cases treated in the Minneapolis General Hospital. Since his report, several clinics in this country and one in Great Britain have reported gratifying results. Many of the principles advocated by Doctor McPheeters are now followed at the Los Angeles Maternity Service.

REASONS FOR TREATING THE COMPLICATION

A few of the reasons for treating this complication are as follows:

1. To relieve the distressing symptoms and disabilities especially in women whose economic status is such that they must do their own housework.

2. To prevent thrombophlebitis. Dr. C. A. Nicholas reports that in one hundred patients treated at the Margaret Hague Maternity Hospital none developed postpartum thrombophlebitis. However, during the prenatal period three patients refused treatment for marked varicosities, and each of them developed thrombophlebitis.

3. To prevent the danger of excessive hemorrhage from the rupture of vulvar varicosities at the time of delivery.

4. To eradicate varicose veins which may persist throughout life. The cosmetic effect is gratifying to the patients.

5. To obtain better results: since there is usually some involution of the veins following parturition, the injection of the varicose veins during pregnancy aids in the establishment of a closer contact of the vein wall about the thrombus.

ANATOMY

To be considered are:

1. Great saphenous vein.
2. Small saphenous vein.
3. External pudendal.
4. Superficial circumflex iliac.
5. Superficial epigastric.

All of these veins—superficial, deep, and communicating—have valves with cusps facing upward and inward. These are usually in relation to a tributary vein and distal to it. The valves may have one, two, or three cusps, but most of them are bicuspid.

PHYSIOLOGY

Three factors influence the normal venous flow up the legs:

1. The action of the leg muscles. This is a systolic and diastolic action, and is especially effective in the deep venous system.

2. Negative intra-abdominal pressure produced by the raising of the diaphragm during expiration, which tends to aspirate the blood from the lower extremities. This also has a systolic and diastolic phase.

3. Competent valves which prevent back flow in the veins.

ETIOLOGY

Etiologic factors to be considered include:

1. Hormonal. This seems to be the most important single factor known at the present time.

2. Valvular defects. These may be of infectious or congenital origin.

3. Weakened vein walls with dilatation. These, likewise, may be of congenital or infectious origin.

4. Heredity.

5. Pressure theory. This is no longer accepted as an important factor, since varicose veins develop early in pregnancy. It may, however, be a factor late in pregnancy because of a reduction in the negative intra-abdominal pressure.

PATHOLOGY

The superficial venous system is more frequently involved because of the lack of supporting musculature, and the normal function is disturbed. This change in function may be due to the previously listed etiologic factors, and Bernstein, McPheeters, Kilbourne, Burger, Holder, and others have proved that there is a reverse flow of blood in most varicose veins. Trendelenburg, by his clinical tests, has also proved this fact. This reverse pressure, especially in the long veins, aids in causing progressive destruction of valves, vein-wall dilatation, "spider bursts," and sacculations in which there may be the so-called "resting infections." It is also this reverse pressure which causes most of the patients' symptoms, and pathological changes in the tissue which the veins should drain.

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* From the Department of Obstetrics and Gynecology, School of Medicine, University of Southern California, Los Angeles.

Read before the Obstetrics and Gynecology Section of the California Medical Association at the sixty-seventh annual session, Pasadena, May 9–12, 1938.

DIFFERENTIAL DIAGNOSIS

Diagnosis must take into consideration:

1. Arteriovenous aneurysm.
2. Thrombo-angiitis obliterans (Berger's disease).
3. Arteriosclerosis.
4. Raynaud's disease and similar conditions.
5. Menopausal arthritis (symptoms often thought from varicose veins).
6. Flat feet (symptoms often thought from varicose veins).
7. Neuritis, diabetes, sciatica.
8. Compensatory veins, which are due to a true blockade of deep veins. These should not be injected.

* * *

DANGERS

Dangers include:

1. Pulmonary embolus, mortality rate 0.00754 per cent.
2. Phlebitis.
    (a) Infectious. May be due to poor technique or to "resting infection" present in the vein.
    (b) Chemical. As a rule not serious.
3. Sloughs. Due to poor technique.

* * *

CONTRAINDICATIONS

Contraindications for interference include:

1. The presence of infectious thrombophlebitis.
2. Debilitating conditions, such as cardiac and renal disease.
3. Accidents or injury demanding bed rest.

* * *

TRENDELENBURG TEST AND TECHNIQUE OF INJECTION TREATMENT

A method of procedure should be as follows:

1. Examination of patient.
2. Percussion pulse transmission test (P. P. T.).
3. Principle of injection therapy. In order to obtain the desired result, one must inject into a vein some solution of known concentration, and hold it in contact with the endothelial lining so as to partly destroy it, thus causing the formation of a thrombus. In order to do this, a certain area is trapped off by means of tourniquets or pressure bandages. Inject high!
4. Patient lying on a table, leg elevated to drain out large varices, and tourniquets put in place. This is often necessary to obtain desired concentration in the varicose vein.
5. Injection of vulvar varicosities; pressure bandages in place, held by assistant.

We have thus far treated only patients having a positive or double Trendelenburg. It is believed that by using this principle as our guide the danger of emboli is distinctly reduced.

Patients treated who have delivered	100
Patients treated who have not delivered	50
Total	150

* * *

AGE

Age factor reveals:

15 to 20 years of age	10
20 to 25 years of age	35
25 to 30 years of age	36
30 to 35 years of age	32
35 to 40 years of age	28
40 to —	9
Total	150

HISTORY OF VARICOSE VEINS BEFORE FIRST PREGNANCY

No varicose veins before first pregnancy	146
Varicose veins before first pregnancy	4
Total	150

* * *

HEREDITY

Familial relationships were:

Mothers	48
Sisters	11
Fathers	1
Grandmothers	2

(One grandmother died of infected varicose veins.)

* * *

CHIEF COMPLAINTS

Among major complaints were noted:

Pain	125
Swelling	73
Cramps	69
Burning	35
Heaviness	27
Itching	8
Weakness	7
Fainting	2
Numbness	2
Dizziness	2

* * *

DISABILITY

As to disability, patients were classified:

Class I. Partial disability.

	Cases
(a) Distressing symptome; patient able to do most of her housework	90
(b) Severe symptoms; patient able to do some of her housework	34

Class II. Complete disability:

Patient in bed most of the time, and unable to stand for more than one or two hours	26
Total	150

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MONTH OF PREGNANCY WHEN VARICOSE VEINS WERE FIRST NOTED

	Cases
1st month	44
2nd month	45
3rd month	29
4th month	15
5th month	8
6th month	7
7th month	2
8th month	0
9th month	0

* * *

VARICOSE VEINS NOTED FIRST WITH

	Cases
Gravida I	62
Gravida II	35
Gravida III	28
Gravida IV	4
Gravida V	6
Gravida VI	8
Gravida VII	4
Gravida VIII	2
Gravida IX	0
Gravida X	0
Gravida XI	0
Gravida XII	1
Total	150

Phlebitis	2
Injuries	2
Burns	2

Constitutional Diseases

Thyroid	4
Diabetes	1
Toxemia	1
Hypertension	4

NUMBER OF YEARS SINCE VARICOSE VEINS WERE FIRST NOTED

	Cases
1 year	4
2 years	10
3 years	5
4 years	14
5 years	10
6 years	4
7 years	6
10 years	6
11 years	6
12 years	5
13 years	9
14 years	5
15 years	2
15 to 20 years	6
20 years —	5

* * *

PARITY OF PARTURIENT CANAL

	Cases
Gravida I	7
Gravida II	25
Gravida III	29
Gravida IV	16
Gravida V	19
Gravida VI	18
Gravida VII	11
Gravida VIII	10
Gravida IX	6
Gravida X	3
Gravida XI	1
Gravida XII	4
Gravida XIV	1

* * *

ABORTIONS

	Pregnancies
150 cases	725

	Cases
No abortions in	90
Spontaneous abortions in	34
Criminal abortions in	46

Thirty-four spontaneous abortions in 725 pregnancies, or 4.68 per cent spontaneous abortions.

There seems to be a relationship between this small percentage of spontaneous abortions and progesterone, with progesterone as a possible cause of varicose veins.

* * *

PHYSICAL EXAMINATION

Location of Varicose Veins.

	Cases
Thigh	123
Leg	117
Vulva	29
Buttock	6
Inguinal	1

Veins Involved.

Great saphenous	128
Small saphenous	28
External pudendal	29
Superficial circumflex iliac	6
Superficial epigastric	1

* * *

Circulation Tests.

Trendelenburg:

Positive	132
Double	18
Negative	0

Margin of safety greater if those with a negative Trendelenburg not treated.

Patients with a negative Trendelenburg do not have distressing symptoms.

Percussion pulse transmission test. This simple test aided greatly in locating large veins in thirteen obese patients.

SIZE OF VARICOSE VEINS

	Cases
0.5 centimeters	39
1.0 centimeters	64
1.5 centimeters	39
2.0 centimeters	8

* * *

ENDOCRINE MANIFESTATIONS

	Cases
Alopecia	1
Hirsutism	22
Acromegaly	1
Dwarfism	0
Android type (D. D. type)	42

* * *

ASSOCIATED FINDINGS

	Cases
Telangiectasis	88
Edema	26
Ulceration	5
Dermatitis	5
Cellulitis	1

* * *

TREATMENT AND RESULTS

Equipment Needed.

1. Solution used: Sodium Morrhuate 5 per cent.
2. Syringes: 5 cc.
3. Needles:
    - Short bevel G 23, 1½ inches long.
    - Short bevel B 26, ½ inch long.
4. Tourniquets: ⅜ inch rubber tube.
5. Bandages:
    - (a) Type used in our clinic (previously described).
    - (b) Elastic bandages.
    - (c) Ace bandages.
6. Rubber sponges.
7. Table and stool.
8. Alcohol 70 per cent.

* * *

PERIOD OF GESTATION WHEN VARICOSE VEINS TREATED

All cases were treated irrespective of the period of gestation. There were:

26 cases treated in the seventh month
10 cases treated in the eighth month
3 cases treated in the ninth month

* * *

SITES OF INJECTION

	Injections
Thigh (great saphenous)	191
Leg (small saphenous)	80
Vulva (external pudental)	18
Buttock (superficial circumflex iliac)	3

* * *

NUMBER OF INJECTIONS PER PATIENT

78 cases had 1 injection
33 cases had 2 injections
20 cases had 3 injections
12 cases had 4 injections
5 cases had 5 injections
1 case had 6 injections
1 case had 9 injections

The reason for the small number of injections per patient is that injections were given high.

* * *

REACTIONS

	Cases
No reactions (no subjective symptoms)	113
Chemical phlebitis (some subjective symptoms)	27
Incapacitated (bed rest)	3
Thrombophlebitis	1
Sloughs	0
Unknown (did not return to clinic)	6

(In all cases there must be a reaction—chemical phlebitis—in order to have a result; thus, in the 113 cases listed with no reaction, we mean no subjective symptoms.)

RESULTS

	Cases
Very good (symptom-free, all varicose veins collapsed)	89
Good (symptom-free, most of varicose veins collapsed)	41
Improved (symptoms improved, most varicose veins collapsed)	13
Poor (no change in symptoms or veins)	1
Unknown	6
Total	150

The five ulcer cases mentioned in this series all healed.

* * *

POSTPARTUM EXAMINATIONS

Number returned for six weeks postpartum examination		55
Very good results	46	
Good results	9	

Discoloration at site of injection.

Slight	16
Marked	2
None	37
Total	55

(Fifty-five of the one hundred delivered patients returned, and most of the remaining forty-five were not due for their six weeks' examination at the time this paper was prepared.)

CONCLUSIONS*

1. Varicose veins complicating pregnancy is an obstetrical problem which has been neglected in the past but can be readily cared for by the obstetrician.

2. Distressing symptoms and disabilities can be relieved with little difficulty and comparatively slight risk by the methods described.

3. The incidence of thrombophlebitis may be reduced by treating varicose veins during pregnancy.

4. The danger of hemorrhage from ruptured vulvar varicosities at the time of delivery may be minimized.

5. Better ultimate results are obtained by injecting varicose veins during pregnancy.

6. Hormones (especially progesterone) and heredity appear to be important etiologic factors.

7. In over 78 per cent of the cases, varicose veins appeared in the first trimester, and in over 80 per cent they developed during the first three pregnancies.

8. The dangers and discomforts of varicose veins often persisting throughout the patient's life may be eradicated.

9. There is a greater margin of safety if *only those patients* with a positive or double Trendelenburg are treated.

10. About one-third of the patients in this series were of the Android (dystocia dystrophy) type.

11. Better results may be obtained, and fewer injections are necessary, if the varicose vein is occluded in its most proximal portion.

12. Varicose veins may be treated in any month of pregnancy.

3780 Wilshire Boulevard.

DISCUSSION

Nelson J. Howard, M. D. (350 Post Street, San Francisco).—Doctor McCausland has presented an excellent survey of the varicose state in pregnancy. He has had the temerity to thrombose the varicose veins by injection during the gestational period, and, from the data presented, one would not hesitate to advise that such treatments be carried out in the pregnant woman presenting varicose veins. I rather doubt that, by and large, the postmortem thrombophlebitis of the deep veins of the leg may be prevented by antepartum injection, and such proof would only be forthcoming in a careful study of large groups of patients.

Dr. C. F. Fluhman informs me that in the Stanford Obstetrical Clinic service, vulvar varicosities have not proved either a source of alarming hemorrhage or of postpartem phlebitis. Nevertheless, I agree with Doctor McCausland that such varicosities should be injected early in pregnancy.

As to the hormonal etiology (supposed influence of progestin) in causation of varicose veins, I feel that more work should be done and carefully controlled before this factor is emphasized and completely accepted. It is just as likely that the increased cardiac output and enormously increased pelvic blood flow lead to not only increased flow through the lower limbs, but relative stasis on the venous side. The "uterine souffle" has the characteristic sound of an arteriovenous fistula, though lacking in intensity, and one might regard the pelvic circulation in pregnancy as a physiological arteriovenous fistula, accompanied by dilatation of the distal peripheral veins.

Although the patients treated by Doctor McCausland obtained in most instances relief of discomfort following injections, I am not at all optimistic of permanent relief, and feel that he will find those same patients in need of reinjection for recurrent varicose veins after the passage of several years, whether subsequent pregnancies occur or not. Doctor McCausland could pursue a worth-while investigation in following these same patients up after an interval of three years had elapsed.

⁂

E. M. Lazard, M. D. (1930 Wilshire Boulevard, Los Angeles.—Doctor McCausland's preliminary report of the work being done at the Los Angeles Maternity Clinic in the treatment of varicose veins in pregnancy is a most interesting and timely one. This condition has been temporized with too long, and any method which gives promise of obtaining such favorable and permanent results must arouse the interest of all obstetricians.

I would emphasize, however, (1) the necessity of careful selection of cases with especial consideration of the contraindications to minimize the chances of accidents occurring; and (2) the meticulous carrying out of the technique. His theory that the hormones (especially progesterone) is the most important single etiologic factor is also interesting, and reports of further work along this line are awaited with interest.

⁂

Lyle G. McNeile, M. D. (3780 Wilshire Boulevard, Los Angeles).—The late J. Whitridge Williams, in his discussion of the management of normal pregnancy, stated: "One of the few creditable achievements of American obstetrics is the development of so-called 'prenatal care.' The term has a wider application than the words imply, and may be defined as such supervision and care of the pregnant, parturient, and puerperal woman as will enable her to pass through the dangers of pregnancy and labor with the least possible risk, and to be discharged in such condition that she may fulfill her duties as mother and housewife with a minimal amount of invalidism."

There are few conditions in obstetrics which give rise to more minor symptoms, and to more annoying discomfort to the patient, than is occasioned by varicose veins. Doctor McCausland has shown the extremely high percentage of varicose veins in women which, apparently, are the direct result of pregnancy. Almost without exception, we have been taught, until very recently, that varicosities were caused by pressure during pregnancy; and there are few among us who have not warned our patients about the dangers of circular garters, and who have not told them that such garters were a major causative factor in the production of this condition.

It is now generally agreed, by those who are in a position to know, that pressure is a negligible factor, that circular constriction is of very little importance, and that the most probable etiological factor seems to be certain hormonal changes, the exact nature of which are not clearly understood. Only one single factor, which has been generally recognized in the past, is still unchallenged today. That one factor is the extremely high incidence of varicose veins during pregnancy, and the extreme discomfort which the condition causes.

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* I wish to thank Dr. Lyle McNeile for granting me permission to use material from his department. Also, I should like to express my appreciation to Doctors Hanley, Reynolds, McBurney, and Baker for their assistance and cooperation in making this study possible.

The work done by Doctor McCausland at the Los Angeles Maternity Service has been conducted under the personal observation of the discussant. When we first decided upon the installation of a "Varicose Vein Clinic for Pregnant Women," we did so with the knowledge that, without exception, the authors of even the most recent textbooks on obstetrics warned against the procedure during pregnancy. I have, however, seen so many procedures condemned, and later given the whole-hearted endorsement of the medical profession, that I was not frightened. The results on the first 150 cases have been carefully analyzed by the author, and have far exceeded our most hopeful expectations.

The injection treatment of varicose veins during pregnancy has been recommended to our private patients, and the results have been as striking as those obtained in the clinic.

When judged by the viewpoints which have been held without change during the first thirty-eight years of this century, it is admitted the procedure is so new that it appears to be radical. It appears to the discussant, however, that a period of stagnation, characterized by the attitude that "it was good enough for my father, so it is good enough for me," apparently has passed and that, with increasing frequency, old ideas are being discarded, and increasingly effective therapeutic measures are being substituted for the old midwife treatment.

Many very valuable measures have been discarded in the past, because their improper use resulted in bad results. Many of us can remember the time when the manufacturers of pituitrin recommended its use in cubic centimeter doses to shorten the time of labor, and our memory of the number of ruptured uteri resulting from such treatment is still very vivid.

In order to obtain satisfactory results, the discussant feels it is essential that the physician heed the caution of Doctor McCausland, and use the injection treatment of varicose veins only when the Trendelenburg test is positive or double positive, when no contra-indications are present, and when the operator has thoroughly familiarized himself with all of the general principles involved. When these conditions are met, the treatment of varicosities by injection appears likely to add one additional achievement in our development of prenatal care.

PREVENTORIUM CHILD*

By Harold Guyon Trimble, M.D.
Oakland

Discussion *by Charles L. Ianne, M.D., San Jose; Carl R. Howson, M.D., Los Angeles; Chesley Bush, M.D., Livermore.*

OUR concept of tuberculosis in childhood has changed very materially in recent years. Up to the classical work of Opie and McPhedran,[1] published from 1926 to 1929, diagnosis was largely on a symptomatic basis. This concept was reflected in the care of this type of children, and summer camps were established to improve their general body condition. This summer camp period may be said to extend roughly from 1910 to 1920. It is interesting that in 1922, at the Washington meeting of the National Tuberculosis Association, a paper by Hubert Rich[2] of Detroit on "The Prevention of Tuberculosis in Childhood," presented in the Sociological Section, was summarized by the chairman as follows: "Any child that has any of these predisposing symptoms: the underweight, the undernourishment, or any of these postural defects, should be followed up with the greatest of care."

SUMMER CAMPS

About this time many people found that summer camps were of no permanent value, though they gave children a temporary boost. These children usually had insufficient medical attention; they were not carefully enough examined before being sent there, nor properly followed up on their return. This led to the development of the twenty-four-hour, every-day, all-year-round institution, limited to children with a positive tuberculin reaction, and frequently to cases of known contact with open cases of tuberculosis. This was called a preventorium. This phase lasted from approximately 1920 to 1935, and continues to some extent to date.

EARLY PREVENTORIA

A pioneer among preventoria was the Lymanhurst School for Tuberculosis in the City of Minneapolis, under the general direction of J. Arthur Myers of the University of Minnesota, a tuberculosis and public health man, and Chester Stewart of Minneapolis, a pediatrician. In November, 1932, they summarized their views. These have since been extended in articles and books,[3] though not materially changed. Chester Stewart,[4] in discussing the question of prognosis and treatment of resolving parenchymal tuberculosis of first infection in infants and children, brings out the facts that these infants and children quite uniformly tend to recover, if removed promptly from sources of infection and are subsequently protected from reinfection; that no special therapeutic measures have been developed for these children; that institutional care is not necessary, but that it is more feasible to keep the child in its own home or suitable foster home under adequate medical supervision. This was a profound reversal of opinion on their part, but is based on careful follow-up of a large series of Minneapolis children.

It so happens that in Alameda County, Ann Martin[5] had followed a similar group of children, though much smaller, and had come to the same conclusion.

VALUE OF PREVENTORIA

In 1935, in the Transactions of the National Tuberculosis Association at their Saranac meeting, and, subsequently, John B. Hawes, II,[6] of Boston, who for many years has supervised the Prendergast Preventorium there, discussed the question: "Are preventoria and summer camps worth while?" The conclusion that he reaches is that he "knows of no more effective way that our present knowledge of tuberculosis can be extended than through these means, provided active and practical measures are used to educate not only the children in principles of health and hygiene, but also parents and other members of the family, and general public; and particularly doctors, nurses, and social workers." Hawes has carried this general theme through subsequent discussions in various places.

Finally, in 1937,[7] at the annual meeting of the National Tuberculosis Association in Milwaukee, Stewart again summarized the position of the Lymanhurst group, and said: "Study of clinical characteristics, therapeutic requirements, and relative contagiousness of different clinical varieties of tuberculosis, supplies evidence which suggests the advisability of discontinuing the use of preventoria for the care of children with primary tuberculosis, and converting these institutions into hospitals for patients with serious and actively communicable reinfection forms of the disease." In other words, take the present preventorium buildings and convert them into hospitals for children or adults!

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* Read before the Pediatric Section of the California Medical Association at the sixty-seventh annual session, Pasadena, May 9-12, 1938.

We see that there has been a change in the general feeling with regard to what we have come to know as a preventorium. My own observation makes me subscribe to Stewart's views so far as the necessity for institutional care for the average type of child seen under preventorium conditions. I believe, however, that a different solution than entire change is the proper one, and in that respect Hawes is correct. Fundamentally, I think there is no real disagreement between these two physicians, but I think they are talking about comparatively different things. As a matter of fact, the Prendergast Preventorium in Boston has accommodated a comparatively large group of diabetic children, for their education in the technique of administering insulin, handling their diets, and training in health habits to improve general hygiene.

Lymanhurst Preventorium has changed its name to the Lymanhurst Health Center. When I last visited there a year ago, the beds, previously used for children with tuberclulosis, were caring for patients—with heart cases discovered in routine school examinations in the City of Minneapolis—that needed confinement to bed or limited regimens. Lymanhurst has always been an integral part of the public school system of Minneapolis.

CALIFORNIA ACTIVITIES

Let us now turn to California. In tuberculosis work, California in many respects has been the leader, and in practically all respects has kept well up with the leading developments, both in individual care and in the public health field. It has been interesting that, in connection with the care of children in the summer camp and preventorium groups, the medical responsibility has rested on the physician concerned primarily with tuberculosis. At times there has been a pediatrician called in as a consultant, but his responsibility has usually been nominal, and in many instances (I believe in most) pediatric advice has not been sought or utilized. The reason for this, is of course, clear. These institutions were started almost universally by the local tuberculosis associations out of seal sale funds. For the purpose of economy in administration, they were usually placed close to the local tuberculosis sanatorium, where one existed. The children went through the tuberculosis clinics, were examined routinely there, were not seen by pediatricians uniformly and, because of the financial interest by the tuberculosis association, the natural tendency was to turn to tuberculosis men. Because of the proximity of these institutions to the sanatoria, there has been a drifting away from the pediatrician's guidance even in the small degree that sometimes existed.

AUTHOR'S COMMENTS

I should like to emphasize that, due to the changing viewpoint with regard to the effectiveness of the preventorium, there are in many places splendidly equipped buildings with excellent physical facilities. Certain problems arise in the course of a pediatrician's practice in which the child does not need hospitalization, care in the child's home is not quite adequate, yet institutional care of a certain type is advisable. There are such places throughout California where adequate care has been given in a fairly well organized fashion for some years. I refer, among others, particularly to the Contra Costa County Preventorium and to the Alameda County Preventorium, a county institution, so-called Del Valle.

I should like to point out very forcibly, however, that, as far as tuberculosis associations are concerned, the use of seal sale funds for other than problems that bear very directly upon tuberculosis is not justifiable; that preventoria, if used for other purposes than that for which they were originally built, should be financed through other sources, preferably as county institutions.

CONTRA COSTA COUNTY EXPERIENCE

What types of children, then, would be suitable for care in a preventorium of a sort that I have in mind? Let me present to you, briefly, our own experience.

It came about in this fashion: In Contra Costa County this preventorium has for some years been almost entirely supported from county funds, but is under the supervision of the Tuberculosis Association. A good resident staff, carefully trained, exists, and ample facilities are available for care of children who are not ill, in the usual sense of the word. Some 600-odd children have been through the institution in the last ten years, and careful follow-up has been instituted. Due to the general drop in the incidence of adult tuberculosis throughout the country, as well as locally, and a careful follow-up of known contacts, the number of children becoming infected with tuberculosis seems to be less year by year, and there were not sufficient children available of the type for which the institution was originally set up to keep the beds filled. Some time previously it had come to our attention that many of the children with positive tuberculins, who had been cared for, had minor behavior problems which were not very well handled by us, and which had a distinct bearing upon their physical condition. A trained psychologist became available on a part-time basis, and with her help it was soon evident that a great deal could be done, even with comparatively meager facilities. Parents were contacted and led to visit the Preventorium, and consulted with the physician and the head nurse, as well as the psychologist. The family situation was gone into, and the cause of many of these minor behavior problems understood. After this, the follow-up reports showed more children were maintaining robust health than had previously been the case.

This stimulated interest still further, so that definite arrangements were made with the two psychologists in the county school department to supervise the Preventorium children. Children coming to preventoria were of school age, and had been known previously to these workers. This, of course, greatly facilitated matters. Many of these minor behavior problems had not been recognized at home, by the teacher or the school nurse. Under this arrangement more careful and more extensive work could be done. There were better arrangements for visiting the children's homes, and closer following up through the school nurse and the teacher. During the last three years practically half of the children to enter this Preventorium have been of this type.

OTHER PREVENTORIA IN CALIFORNIA

In most of the preventoria up and down the State, a large number of children not well, but with no organic disease of significance, are patients for from six months to a year or more. They are discharged often upon pressure from the parents, or upon pressure of a waiting list. There is no special effort made to correct other than purely physical problems. Their lack of general adjustment is reflected into their physical condition. More and more the local doctors have come to recognize this, and the preventorium is receiving these children. Many fall into the age group from six to eight years. It is when they first enter the school system that their lack of adjustment becomes evident, and this is increasingly reflected into the child's physical condition. Most of the time these children have had teeth repaired, tonsils removed and frequently some type of supervised rest plus heliotherapy. A large number of these children are improved by the work of the psychologist in the school, the nurse, and the teacher, together with midday rest. As a rule, they all have had careful and adequate physical surveys by their own family physician. These measures frequently suffice.

There is always a small residue, however, in which the parents need the demonstration of institutional care, of what can and should be done on their own child. A child who previously has been somewhat of a problem with regard to eating, with regard to bed wetting, with regard to study in school, with regard to frequency of colds, with regard to disposition, and with regard to play, within a few weeks is transformed into what is very obviously a normal, healthy, happy youngster. The institution or physician who brings this about is then in a position to speak very frankly and very definitely to the parents. As a rule the parents are interested. Occasionally one finds an entire disinterest on their part, more often a broken home, and then, of course, the problem becomes much more difficult.

A SPECIAL FUNCTION OF THE PREVENTORIUM

I must describe briefly an entirely different sort of problem, the care of which the preventorium is eminently fitted for; that is, bridging the gap between hospital and home in many different diseases. There are particularly the heart case, empyema, acute nephritis, osteomyelitis, burns, recurrent respiratory infections, and many other infections and diseases of less frequent occurrence. The preventorium technique, if I may call it such, is well adapted for this transition between the usual hospital care and home supervision. This has been particularly well developed in the Alameda County institution at Del Valle, and the long-time results are very satisfactory.

ECONOMIC PROBLEMS

I hesitate to enter into the controversial field of medical economics. Admission requirements must of necessity vary from county to county. A strict application of financial eligibility standards is, of course, necessary, for a county institution must conform to the law. Those institutions under a tuberculosis association or other private auspices are bound by no such legal requirements, and are more flexible when it comes to consideration of part-pay groups of patients. It would seem much better that parents pay something for the cost of their child's care, if at all possible. In Contra Costa County an attempt is made to have most of the parents pay something. While this amount may be very small, and may not begin to take care of the actual cost, we have found that this stimulates interest on the part of the parents. Something they get for nothing is frequently valued as just about that worth.

EDUCATIONAL VALUE OF THE PREVENTORIUM

There is great possibility in the preventorium as an educational institution for certain individual parents, for certain individual physicians, for many nurses and for the public at large. The preventorium has been in the hands of men who have done well, but whose interest is mostly in adult medicine and primarily in the field of diseases of the chest. Many important fundamental pediatric problems have not been recognized in these children. I should like to see the trend away from this, and to see pediatricians have more interest in the preventorium, as such, because a certain small but definite percentage of their patients will profit tremendously from such an experience.

The preventorium idea should not be abandoned. Our present institutions should be adapted for these new purposes, preferably under careful adequate pediatric supervision, to the end that the number of well-adjusted children with sound bodies may be greatly increased in our various communities.

IN CONCLUSION

Our concept of childhood tuberculosis has changed materially since 1920. During this time many structures have been erected for the care of children who were presumably pretuberculous. There is but little need in many areas for these structures, for the purpose for which they were originally intended. Such institutions can be used not only as educational centers, but also in specific cases in helping solve physical and psychological problems other than tuberculosis in individual children, as well as providing care, for a limited time, for a few selected cases of tuberculosis.

508 Sixteenth Street.

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DISCUSSION

Charles L. Ianne, M.D. (Santa Clara County Hospital, San Jose).—Doctor Trimble has given us a concise and interesting history of the Preventorium Movement. He especially elaborates on the reason for its connection with Tuberculosis Sanatoria and why these institutions were manned by tuberculosis specialists.

My experience with preventorium work dates from the opening of the Del Valle Preventorium that Doctor Trimble mentions. I feel, like Doctor Trimble and Doctor Hawes, that these institutions have filled a great need in the antituberculosis movement. There are some who think that instead of spending money on these institutions, more emphasis should have been put on isolating the "carrier." I wonder how cognizant the public would have been of the "carrier" and his effect on children if preventoria had not been established.

Statistics are not always interesting, but doubting Thomases must be convinced; hence our experience at Sunnyholme Preventorium in Santa Clara County may be of value: In the interval between 1923 and 1933, 428 children had been discharged from the preventorium. A survey of this group was made between 1928 and 1933 (the ages then ranging between 9 and 20). This survey showed that only six patients had developed reinfection type of tuberculosis. One died owing to failure to coöperate in the follow-up, and the other five, after a short period of sanatorium care, returned to their homes in good health. On the other hand, in the same five-year period (1928-1933) 110 patients, of the same age group, who had not had preventorium care, were admitted to the Santa Clara County Sanatorium. Both groups came from the same social strata. Many had satisfactory homes where the source had either died or been removed to the sanatorium, the only difference being that the former group received the extra physical boost afforded by the preventorium and the advantage of concentrated health education. Perhaps the educational value to the community is the greatest benefit derived from the preventorium. The parents of the preventorium children become acquainted with the preventorium routine and purposes, and through the interest of the Parent-Teacher Associations and Service Clubs the community gradually becomes "tuberculosis-prevention" conscious.

Doctor Trimble mentions that Preventoria are gradually enlarging their field to include the care of convalescents from other diseases; that they are being staffed by pediatricians and other workers trained in childhood psychology. He emphasizes the importance of the teaching value of these institutions in training doctors, nurses, public health workers, and parents.

In my talks to lay audiences I always refer to the Preventorium as the "farm center" where the community may learn better methods for the growth and development of its most important "crop"—the next generation.

* * *

Carl R. Howson, M. D. (1930 Wilshire Boulevard, Los Angeles).—Doctor Trimble has set forth very clearly what, to my mind, is the best thought regarding the status of the preventorium.

Originally, the preventorium was designed for the care of the pretuberculous child. As time went on we found that the pretuberculous child was nonexistent; that children falling into such a classification did not develop tuberculosis with any greater frequency than did the average group of children.

When the increasing use of the x-ray revealed the lesions of first infections in the lungs of young children, we were appalled at the extent of the apparent pathology. Many years of observation were necessary before we could be convinced of the relatively innocuousness of these infections and the amazing manner in which the lung fields eventually cleared, leaving the familiar Ghon tubercle. A most striking demonstration of this was the work of Myers and Stewart at Lymanhurst, to which Doctor Trimble refers.

In the swing of opinion away from our former concept there is sometimes a tendency to overlook one qualification made by these investigators in regard to these primary infections: they stress the good prognosis, "if the child is removed promptly from sources of infection and subsequently protected from reinfection." If these children are of the types outlined by Doctor Trimble, the need for institutional care still exists.

In view of the frequency of the finding of tubercle bacilli in the stomach washings of children with primary parenchymal lesions, it is obvious they should be segregated, preferably in separate buildings or institutions.

Full utilization of the value of institutional care can be obtained only when the home conditions are studied carefully and corrections made when indicated. Psychological study and treatment of many of the children are needed; and perhaps even more necessary is similar treatment for one or both parents.

* * *

Chesley Bush, M. D. (Livermore).—When we see on the screen a picture of long-coated Southerners with shotguns, prohibiting passengers from New Orleans alighting from the cars because they came from a city infested with yellow fever, we laugh; and laugh because we now know that is not the way to control yellow fever.

We now know, also, that putting malnourished children into summer camps and preventoria is not the way to control tuberculosis; but the old ideas of 1920 are still predominant in many parts of our country, and the newer knowledge has not yet caught up. Money that should be expended in institutionalization and treatment of the adult source of infection is being spent in the more dramatic and inspiring care of children.

What shall we do with our "preventoria"?

In Alameda County we have an eighty-bed preventorium. In 1939 we would have difficulty in finding eighty children with positive tuberculin tests who come from tuberculous families, and who are under par. We have had difficulty in finding thirty children with active tuberculous disease to fill our sanatorium children's department for the past five years. So we have closed this department as a children's sanatorium and made it available for adult patients. We have consolidated all children's work in Del Valle—making one isolated unit for primary active tuberculosis of childhood; one ward for the convalescent care of any pediatric or surgical condition; and one ward for the type of child mentioned by Doctor Trimble.

In Alameda County today, with six hundred thousand population, we have fifteen cases of bone and joint, and primary lung tuberculosis, among young children hospitalized at Del Valle. Tuberculosis is becoming a rare disease among children of the two to twelve age group in our community.

Let us abolish any connection between the word "preventorium" and tuberculosis. A "preventorium," if we must preserve the word, is a "children's health school."

* * *

H. G. Trimble, *Closing.*—I should like to thank the discussants for their kind treatment. It is interesting that we all agree so closely on what has been a controversial subject. California has long been among the leaders in putting into effective action, on a wide scale, modern advances in the general health field, including tuberculosis.

I can only hope that the ideas expressed may soon bear fruit, encouraging institutions of the general type known as preventoria to make their programs more effective and fulfill the needs in the child health field for which they can so readily be adapted.

SCABIES*

ITS TREATMENT WITH BENZOYL BENZOATE, AS COMPARED WITH SODIUM THIOSULPHATE PLUS HYDROCHLORIC ACID

By Arne Ely Ingels, M.D.
San Francisco

Discussion *by Henry J. Templeton, M.D., Oakland; C. Russell Anderson, M.D., Los Angeles; Harry E. Alderson, M.D., San Francisco.*

"THE seven-year itch," or scabies, has deserved its name on account of the lack of response to methods in use up to the last few years. This may have been due, in part, because the regimen employed during a cure would often neglect important factors, like contamination from other members in a family and disinfecting measures. Thus reinfections would often run a year-long cycle.

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* Read before the Dermatology and Syphilology Section of the California Medical Association at the sixty-seventh annual session, Pasadena, May 9-12, 1938.

DANISH OINTMENT

Danish ointment was the merited cure for scabies since reported by E. Ehlers, in 1921.[1]

Modifications of this, containing Balsam of Peru and precipitated sulphur, have been in use since Caesar Boeck's days.

Arthur M. Greenwood and Margaret Reilly[2] report the successful treatment of 2,582 cases of scabies by the so-called Danish method at the Massachusetts General Hospital. This method was used for ten years, with particular attention to the accurate formula, preparation and regimen. No detailed case reports, however, are given.

Anyone who has used the Danish method will know the untoward reactions, like dermatitis venenata, and distressing itching conditions which may develop.

OTHER METHODS

A great advance in treatment was the employment of the combined "cure," with 40 per cent sodium thiosulphate and 4 per cent dilute HCl (by Raveant and Mahien).[3] The active principle is H_2S, which is liberated when HCl comes in contact with the sodium thiosulphate. The sodium thiosulphate was rubbed into the skin and allowed to dry, whereupon the diluted HCl was applied and also allowed to dry. The same procedure was repeated the next day when, after a bath, the patient was told not to repeat the application without permission. From last-mentioned and other reports, wherein modifications of this method were employed, it seemed justified to draw optimistic conclusions. G. V. Kulchar and W. M. Meininger treated fifty cases of scabies according to this method, showing satisfactory results.[5]

Thirty patients treated by me according to the above system, at Stanford University Hospital and in my private practice, showed persistence of the scabies lesions in four cases. Five cases showed a mild dermatitis venenata. A great number complained of aggravated or distressing itchy sensations, which betrayed the peculiar tenacity characteristic of a sulphur dermatitis. However, instructions seemed to have been followed accurately, and the druggist's product was checked in instances where there was doubt. The patients were selected from all age groups, free from secondary infections and other skin manifestations. Where such were present, the itching and smarting in the days following were severe enough to lead one to abstain from the scabies treatment until the other manifestations had been alleviated or cleared up.

A repetition of the cure, with or without the physician's consent, aggravated the symptoms considerably. Two cases were hospitalized four to six weeks for the dermatitis venenata, which had developed in this manner. Altogether, the relatively complicated regimen, and the nature of the remedies employed, made it imperative to check the unintelligent patient and the accurate filling of the prescriptions.

KISMEYER'S REPORT

In 1937, A. Kismeyer[4] reported eight thousand cases treated with benzoyl benzoate, sapo mollis, and iso-propyl alcohol, 75 per cent, each equal parts, at the "Kommune Hospital" in Copenhagen. After soaking the patient for ten minutes in a bath, the mixture was brushed into the skin for five minutes. After drying, another application was brushed in. Twenty-four hours after, a bath was taken, and underwear and bedding changed.

The active principles would be (1) benzoyl benzoate, which is a balsam of Peru distillate; (2) the keratolytic soap; and (3) isopropyl alcohol.

AUTHOR'S SERIES

This same schedule was applied in my series of ninety cases, excepting the brushing, and that plain 75 per cent alcohol was employed in half of the cases. In the first twenty cases, the solution was rubbed in with a soft brush. In the subsequent cases, the mixture was rubbed in with the flip of a washrag, or with the hands only. This last seemed easier, simpler, and served the purpose.

Only cases without secondary infection, or eczematous conditions, are included. All ages and all types of skin were represented. The ninety cases cleared up promptly without a repetition of the "cure." No case of dermatitis venenata developed. One case of severe itching, but without visible skin changes, developed in a person who had been using soap and water in excess, after the "cure," and only a few cases showed mild itching. Oiling the skin, and refraining from soap and water a few days, promptly alleviated the symptoms.

I might add that three patients who showed recurrence after the sodium thiosulphate plus hydrochloric acid "cure" cleared up promptly after the benzoyl benzoate "cure."

An additional, smaller series of scabies, with impetiginous lesions and secondary dermatitis, responded under the benzoyl benzoate cure, with healing of both scabies and the impetigo. Subacute dermatitis, from prolonged scratching, faulty application or filling of the prescription, seemed to stand the method well, whereas analogous cases treated with sodium thiosulphate plus hydrochloric acid showed accentuation of the condition in question. Thus the injured skin showed much sharper reactions subjectively and clinically. It was further observed that the safety margin, or therapeutic latitude, showed very favorably with benzoyl benzoate. For example, when the cure had been repeated once or several times, intentionally or by misunderstanding from the patient, the worst consequence was only increased itching and only a mild dermatitis venenata. In a patient who had been applying the benzoyl benzoate for one week, mild dermatitis venenata developed. With sodium thiosulphate dermatitis venenata was frequently seen in repeated cases. I might, finally, add that in all the cases the diagnostic landmarks were the appearance of the typical scabies lesion, with the burrow and their distribution, and nocturnal itching, in addition to the demonstration of the acarus scabiei when it was possible.

For both systems, the usual scabies regimen was employed, paying particular attention to scabies in the family, etc.

All the "cures" were started with thorough bathing and cleaning with soap, change of underwear, bedding, and possibly dry cleaning of clothes. Each patient received an instruction sheet and was told to report.

COMMENT

It is noteworthy that a second "cure" was unnecessary with the benzoyl benzoate method. I shall not count one case where, without my knowledge, the course was repeated three days after the finish of the first course. Even the experienced dermatologist would be unable to judge the final result after three to four days. For example, it is a known fact that the chronic scabies papule, with reactive inflammation in the skin, often takes weeks to involute, particularly on the shaft of the penis.

Discussion.—In interpreting various reports it is interesting to notice the good results with the Danish cure, reported by Greenwood and Reilly. However, accurate data are not supplied in the statistics, and no mention made of individual cases.

The sodium thiosulphate plus hydrochloric acid method is undoubtedly a great improvement over the last. Its enthusiastic reports should not be doubted. Disadvantages, amongst which the observed redness, or dermatitis venenata, of the skin and grave itching are the most obvious, justifies a search for further perfection.

The reported series of ninety cases treated with benzoyl benzoate-sapo mollis-alcohol, compared with an approximately equal number of aforementioned, justifies optimistic conclusions.

CONCLUSIONS

1. The benzoyl benzoate cure was the most effective in these two series.
2. It is simple and cheap.
3. Secondary effects, like dermatitis venenata, were absent, itching negligible.
4. Impetinginized scabies lesions, which responded strikingly with the benzoyl benzoate cure, were protracted or aggravated with sodium thiosulphate plus hydrochloric acid.
5. The safety margin of benzoyl benzoate "cure" has a great advantage over that of the sodium thiosulphate cure, particularly where "misunderstandings" have occurred.
6. In a few cases, the "one application" method with benzoyl benzoate has been promising, and is being tried out.

490 Post Street.

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DISCUSSION

Henry J. Templeton, M. D. (3115 Webster Street, Oakland).—The old orthodox treatment of scabies by means of sulphur ointment is open to several objections. As pointed out by Kingston,[1] it occasionally fails to kill the acari even after proper application. I have noted this same drawback in a number of cases. Next, it produces a fairly high incidence of sulphur dermatitis, and, lastly, it is "messy" and time-consuming.

The method described by the author would seem to materially simplify the treatment of scabies. I have used it in about a dozen cases in my private practice, and with considerable satisfaction; but many more cases must be treated and results appraised before we finally can evaluate it.

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C. Russell Anderson, M. D. (1930 Wilshire Boulevard, Los Angeles).—Any improvement in the treatment of scabies is welcome, and I am sure that every physician will appreciate the points brought out in Doctor Ingels' study.

He mentions the tenacity of sulphur dermatitis, whose duration at times varies from four to six weeks in spite of all types of soothing applications. Pyrethrum ointment has been used with success by some physicians. Although sulphur dermatitis is then avoided, many dermatologists hesitate to use it for fear of producing a pyrethrum sensitivity, which would be disastrous in view of the widespread use of pyrethrum in insecticides.

The short period of treatment with the benzyl benzoate mixture, the simplicity of application, the uniformly good results, and the relative freedom from treatment dermatitis, merit the attention of every physician who has occasion to prescribe for scabies.

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Harry E. Alderson, M. D. (490 Post Street, San Francisco).—I am glad that Doctor Ingels mentioned the difficulty that one experiences in obtaining complete coöperation on the part of the patient and family. Such a little oversight as that of failing to clean the toilet seats thoroughly may account of recurrences. I believe that the spread of scabies in schools is often due to contamination of toilet seats. The tendency for sulphur dermatitis to develop promptly in some patients increases our difficulties. Many patients, before consulting a dermatologist, have already tried various neighborhood and drug-store remedies containing sulphur, and, of course, promptly feel the bad effects of further sulphur medication.

The sodium thiosulphate and acid combination is quite useful, but we see too many recurrences, or, shall we say, failures to achieve a complete cure by this method.

The benzoyl benzoate treatment has proved its usefulness, but even that method is not 100 per cent effective. In some countries plain balsam of Peru has been used, having the patients anoint completely the entire body, and good results thereby are obtained; but frequently renal irritation has developed. The benzoyl benzoate, a derivative of balsam of Peru, might be expected to produce toxic effects, but so far I have not observed any. I believe the method is quite valuable, and shall continue using it in cases where good coöperation can be obtained, but I expect also to have to use sulphur in some cases.

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ROENTGEN DIAGNOSIS OF DISEASES OF THE ILEOCECAL REGION OF THE GASTRO-INTESTINAL TRACT*

By Joseph Jellen, M.D.
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Discussion *by Charles M. Richards, M. D., San Jose; Henry Snure, M. D., Los Angeles.*

PART II†

NONSPECIFIC ULCERATIVE GRANULOMAS (REGIONAL ILEITIS)

SINCE the description of regional ileitis in 1932 there has been an active interest in the subject of benign inflammatory granulomas. In a previous communication[3] the writer presented a detailed study of the clinical, pathological, and roentgen

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Read before the Radiology Section of the California Medical Association at the sixty-seventh annual session, Pasadena, May 9–12, 1938.

† Part I of this paper appeared in the issue of March, 1939, on page 188.

findings in a series of fifty cases, and the reader is referred thereto for a comprehensive discussion of the subject. Pathologically, the disease is characterized by a cicatrizing inflammatory process, which produces extensive stenosis of the intestinal lumen. There is a definite predilection for involvement of the terminal ileum in a large majority of the cases. However, the disease may involve other portions of the gastro-intestinal tract. A similar pathological process has been noted in the jejunum and in the proximal portions of the ileum. In some cases there is extension of the granuloma from the terminal ileum into the colon. In other instances the granuloma of the ileum is associated with a nonspecific ulcerative colitis. External and internal abdominal fistulae are often present. The disease is most often seen in young adults. Abdominal cramps, diarrhea, and loss of weight are the most frequent symptoms. At times the symptoms are minimal, and consist of mild abdominal discomfort. On physical examination, a palpable mass is often found, usually in the right lower quadrant of the abdomen. On all suspected cases, special study of the small intestine is advisable. A satisfactory procedure is to take films at two, four, six, and eight hours after the ingestion of the barium meal. The essential roentgen finding is the demonstration of a narrow and stenotic segment of intestine. The treatment of these inflammatory granulomas is surgical, and resection of the diseased intestine is indicated. This procedure usually results in a cure.

SECONDARY INFLAMMATORY GRANULOMAS

Inflammatory granulomas secondary to appendicitis, typhlitis, and diverticulitis have been described in the literature. Donchess and Warren [4] reported a granuloma involving the cecum and ascending colon, which apparently developed from appendicitis. They mentioned twenty-four cases of granulomas involving the cecum and colon. In seven of these the ileum was also involved. In these secondary granulomas, there is usually thickening and induration of the cecum, pericecal adhesions, and enlargement of the regional lymph nodes, all of which contribute to the palpable mass which is often present clinically. There is usually no mucosal ulceration, a point which differentiates them from a primary nonspecific granuloma, such as regional ileitis. Clinically, these patients complain of recurrent abdominal pain or the presence of a mass in the abdomen. The roentgen examination reveals cecal irregularity, with narrowing of the lumen. At times a semilunar filling defect in the cecum is noted, resulting from pressure of the adjacent inflammatory mass.

PERI-INTESTINAL GRANULOMAS

Granulomas of the intestine which develop secondary to slowly perforating lesions of the bowel are usually caused by a foreign body, such as a fishbone or toothpick. These inflammatory masses are peri-intestinal, and do not encroach on the intestinal lumen. There is no mucosal ulceration. Clinically, these cases present themselves with a palpable mass in the abdomen. Because of the absence of intramural involvement of the bowel in this type of granuloma, the barium meal and enema are usually negative. Occasionally, there is persistent spasm of the intestine adjacent to the lesion. At operation these granulomas resemble malignancy. On examination, however, they are found to be benign inflammatory masses. The etiologic foreign body is often found imbedded in the granuloma.

LYMPHOBLASTOMA

Hodgkin's disease, lymphosarcoma, and follicular lymphoblastoma are all considered in the group of lymphoblastoma. These tumors may involve various parts of the gastro-intestinal tract. They are most commonly found in the ileocecal region. Grossly, the lesions appear as annular, polypoid, or subserous growths. In lymphosarcoma there is a rather characteristic tendency to aneurysmal dilatation of the lumen of the involved segment of intestine. Stenosis of the bowel, when present, is usually due to pressure from metastatic glands in the mesentery. The gastro-intestinal symptoms are not charcteristic. When the growth is of the polypoid type, a mass may be palpable in the abdomen. The clinical picture is often that of acute or chronic intestinal obstruction. There does not appear to be any characteristic roentgen appearance. In some cases with a polypoid growth there is a filling defect in the involved area. In others, where the disease is infiltrative, there are irregular areas of constriction and dilatation in the intestine. The presence of a localized dilatation of the intestine, associated with a palpable mass, is suggestive of lymphosarcoma. When the cecum is involved, thickening and distortion of the mucosal markings may be noted. Coincident lesions of the stomach and intestine suggest the possibility of lymphoblastoma. In a series of 107 cases of gastro-intestinal lymphoblastoma, associated lesions of the stomach and intestine were found in 28 per cent. In many cases of suspected lymphoblastoma, the diagnosis is facilitated by the presence of generalized glandular or splenic enlargement. In others the presence of an associated mediastinal tumor makes the diagnosis evident. At times the diagnosis may rest on the biopsy of a palpable lymph node.

APPENDICEAL INFECTIONS

The diagnosis of a chronic appendicitis is occasionally offered by the roentgenologist. Fixation of the appendix, associated with definite localized tenderness of the visualized appendix, constitute the most valuable signs. In addition, kinking of the appendix, irregular narrowing of the lumen, segmentation of the barium shadow, and stasis of barium in this organ, offer additional evidence of a diseased appendix.

We have observed a moderate number of cases of calcified appendiceal fecaliths. These were seen on the flat plate of the abdomen, taken on suspected cases. They are noted as small calcific shadows present in the right lower quadrant of the abdomen. They measure up to one centimeter in diameter. Occasionally they are almond-shaped, and at times a laminated structure can be demonstrated.

In cases of appendiceal abscess, there is usually a tender palpable mass present in the right lower quadrant of the abdomen. This is demonstrated on the roentgen examination by the presence of a smooth semilunar, pressure defect on the medial aspect of the cecum. It is occasionally associated with displacement of the terminal ileum by the adjacent mass.

INTUSSUSCEPTION

Intussusception is occasionally present in the proximal portion of the colon, and may be of either the ileocecal or cecocolic type. Approximately one-third of the cases are associated with a neoplasm, which is more often benign than malignant. Cases of acute intussusception are usually not referred for roentgen examination, whereas chronic intussusception in adults is occasionally observed. Very often there is a palpable mass present in the abdomen, and blood may be noted in the stools. The roentgen aspects of subacute and chronic intussusception are quite characteristic. There is obstruction to the passage of the barium, demonstrated either by barium meal or enema. A filling defect is noted at the sight of the obstruction. In addition, a characteristic crecentic compression of the mucosal folds in this region is apparent, produced by the invagination of the bowel.

DIVERTICULITIS

Diverticulae are occasionally present in the cecum and ascending colon. In some cases there are solitary; more often there is generalized diverticulosis of the colon. Diverticulae of the cecum and ascending colon without symptoms, are sometimes found as coincidental lesions in gastro-intestinal cases. When there is an associated inflammatory process (diverticulitis), definite symptoms are usually present. To date, approximately twenty cases of primary solitary diverticulitis of the cecum have been reported in the literature.

MESENTERIC ADENITIS

Enlargement of the mesenteric glands is most often encountered in children. The condition may be secondary to various conditions. At times it is associated with acute respiratory infections. In some cases it is secondary to inflammatory ileitis. In tuberculous adenitis the process may progress and end in caseation. If healing occurs, calcification is often the end-result. Patients with mesenteric adenitis are often asymptomatic. At times there is a history of intermittent abdominal pain, and if seen during an acute attack the clinical picture simulates acute appendicitis. Golden[5] has described changes in intestinal physiology associated with calcified mesenteric adenitis. Localized spasm and delay in motility have been noted in adjacent intestinal segments.

LOCALIZED ULCERATIVE COLITIS

Ulcerative colitis may be localized and confined entirely to the proximal portion of the colon, without radiological or sigmoidoscopic evidence of generalized colitis. Amebiasis and tuberculosis are the most common specific causes of proximal colitis. In many instances the condition is apparently nonspecific. In some cases there is retrograde extension and involvement of the terminal ileum. As in generalized colitis, abdominal pain, diarrhea, and bloody stools are the most common complaints. Localized hyperplastic ulcerative colitis, involving the proximal colon, has been described in the literature. In these cases the ulceration is associated with polypoid changes in the mucosa and thickening of the wall of the colon in the involved area. A mass is often palpable clinically. The roentgen examination reveals contraction and narrowing of the cecum and ascending colon, associated with marginal irregularity. In addition, localized irritability and hypermotility are usually present, with distortion and obliteration of the normal mucosal pattern. The changes are more extensive than those seen in malignant disease, and usually are not confused with it.

COMMENT

In view of the large number of disease entities which affect the ileocecal region, it should be recognized that this portion of the gastro-intestinal tract is just as important as the stomach and duodenum, where most of the attention is focused during the routine gastro-intestinal examination. Unless detailed study is made of the ileocecal region, many lesions will pass unrecognized. Many of the hyperplastic lesions are characterized by the presence of a palpable mass in the right lower quadrant of the abdomen, which is usually of obscure origin, and often erroneously designated as carcinoma. It is only after a careful consideration of all the possibilities, coupled with a study of the clinical history and laboratory findings, that one can hope to arrive at the proper diagnosis. It is the writer's opinion that diseases of the ileocecal region offer more difficulty in roentgen diagnosis than any other topographical branch of gastro-enterology.

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DISCUSSION

Charles M. Richards, M.D. (303 Medico-Dental Building, San Jose).—The roentgen examination of the cecum and terminal ileum is too frequently passed over in a more or less perfunctory and routine manner. When the clinical history, which should be provided for the roentgenologist, points to symptoms in this region, the examination deserves to be made with painstaking care.

Doctor Jellen has given us a very comprehensive review of the pathological conditions commonly met with in this region, and some of the less frequent ones. Even a glance at this impressive list should give the roentgenologist reason to give this region its due share of consideration, and the clinician could also study it with much profit to his patients.

A few points concerning pathology in the ileocecal region stand out as particularly important in my mind. First, we, as roentgenologists, must be impressed with the importance of taking the extra pains sometimes necessary to observe the course of the barium meal at odd intervals so as to catch the optimum time for examining the ileum in its relation to the cecum and other contiguous structures. This extra care will occasionally be rewarded by the discovery of signs of great importance.

It used to be the habit of most of us to pass over, with little or no consideration, the discovery of calcified mesenteric lymph nodes. It has been shown us by some investigators, and I have had occasion to corroborate the fact that chronically or acutely inflamed mesenteric lymph nodes may be at the bottom of a train of symptoms for which too often a fruitless appendectomy has been performed.

One other observation which has many times impressed me, and which Doctor Jellen has not stressed, is that the large, hypotonic, sagging, poorly drained cecum, so often seen, which, due to the fact that it is seldom, if ever, fully emptied, becomes chronically irritated and remains to plague the patient with a painful right lower quadrant long after the removal of an appendix is supposed to have eliminated the source of trouble.

If Doctor Jellen had done no more than compile the classified list of pathological conditions to be found in the ileocecal region, he would have done us all a real service.

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Henry Snure, M. D. (333 South McCadden Place, Los Angeles).—Lesions of the ileocecal region, as the author states, present a difficult problem in diagnosis even with the aid of a roentgenologic study, particularly when pain and palpable mass in the lower right quadrant are present. If the case is a chronic one, ample time for the complete roentgenologic study may be available and the correct diagnosis arrived at. Too often in hospital work the patient is admitted as an emergency with a request for a scout film of the abdomen to rule out obstruction and is in no physical condition for a prolonged roentgen study; many times a prompt exploratory operation is advisable rather than any further roentgenologic examination which may or may not provide a correct answer as to the type of pathology present.

Several years ago I made films of an infant, showing free air in the abdomen. Autopsy later showed a pin-point perforation of the cecum, the cause of which could not be determined. In this case operation was promptly done, but did not save the patient's life nor establish definitely the cause of perforation.

Doctor Jellen lists some forty types of lesions that may be present in the ileocecal region; fortunately some of these lesions occur rather infrequently, thereby reducing the percentage of possible errors in diagnosis. One point that should be emphasized is that the lymphoblastomas give no characteristic roentgenographic appearance. The diagnosis is usually made by biopsy at the time of operation.

I was glad to hear Doctor Jellen state that the diagnosis of chronic appendicitis is only occasionally offered by the roentgenologist; the various changes in the roentgenographic shadow of the appendix are of little value, location of pain point over the appendix and that shifts with the appendix is of value. He also states that the roentgenographic appearance of an appendiceal abscess is usually a smooth pressure defect on the mesial side of the cecum. However, I have occasionally found an irregular defect of the cecal outline laterally in appendiceal abscess that suggested carcinoma.

The author deserves credit for the very thorough and comprehensive manner in which he has presented the lesions of the ileocecal region.

VITAMIN-DEFICIENCY STATES: THEIR RECOGNITION AND TREATMENT*

By Dwight L. Wilbur, M.D.
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Discussion *by William C. Boeck, M. D., Los Angeles; Albert H. Rowe, M. D., San Francisco.*

PART II†

DEFICIENCY OF P-P FACTOR (VITAMIN G, B_2, NICOTINIC ACID?)

Symptoms.

Deficiency of this factor leads to the development of pellagra, the characteristic symptoms of which are three D's—diarrhea, dementia, and dermatitis—but these occur simultaneously in severe cases only. Perhaps the most characteristic feature is the dermatitis, without which the diagnosis is questionable. The cutaneous lesions consist of a dermatitis suggesting sunburn; a reddened, dirty brown skin, parchment-like, rough and scaling and affecting principally the exposed surface, especially the backs of the hands, wrists and forearms, usually in a symmetrical fashion. The face, neck, genitalia, and legs may be similarly affected. Gastro-intestinal symptoms which accompany pellagra are variable, although severe glossitis and diarrhea are the most common. The stomatitis may consist of a brick-red color of the tongue, gums and cheeks, or there may be, in addition, considerable edema, ulceration, and exudation. Diarrhea may be intractable. Anorexia, vague abdominal distress and, at times, constipation may be present. Loss of weight is common, as are also nervous symptoms such as those of peripheral neuritis or of neurasthenia, namely, exhaustion, lassitude, and insomnia. The occurrence of any of these symptoms, accompanied by dermatitis of the type mentioned, should suggest the possibility of pellagra.

Diagnosis.

The diagnosis of pellagra depends entirely on the symptoms. While diagnostic and laboratory tests have not been developed, therapeutic test with nicotinic acid is proving of considerable diagnostic value.

Mild degrees of deficiency of the P-P factor are not clear-cut and little is known about them. The occurrence of otherwise unexplained glossitis, or vague gastro-intestinal symptoms with diarrhea, with or without symptoms referable to the nervous system, have been thought by some observers to be due to early pellagra or deficiency of vitamin G, (B_2). The therapeutic effect of nicotinic acid in such cases may be of considerable diagnostic value if psychic influences can be controlled.

Treatment.

The daily requirement of the P-P factor or of nicotinic acid is unknown; nevertheless, the treatment of pellagra has become very effective, largely as a result of the work of Spies and his associates. It has been shown that the effective measures in treatment are a diet high in calories, proteins and vitamins (3,500 to 4,000 calories), supplemented by nicotinic acid in doses of 500 to 1,000 milligrams, by thiamin chlorid in doses of 20 to 50 milligrams, by powdered brewers' yeast in doses of 75 to 150 grams, or by dilute liver extract in doses of 25 to 75 cubic centimeters daily. Early in the course of the treatment the vitamin supplements may be administered parentally to those patients who, because of a sore mouth or vomiting, cannot tolerate an adequate diet. Bed rest, good nursing care and symptomatic treatment, consisting of sedatives, antiseptic solutions (such as potassium permanganate 1:5000 applied to the skin, and tincture of opium in large doses to control diarrhea), are also valuable adjuncts in treatment.

Since pellagra of the secondary type occurs not uncommonly in association with organic lesions in the gastro-intestinal tract, particularly with those which produce obstruction and with malignant disease of the stomach and colon, it is important to exclude gastro-intestinal disease before dismissing the patient.

Anemia—Abnormalities in the Gastro-Intestinal Tract.

Little is known of the etiologic factor or factors leading to the development of a macrocytic anemia, which is commonly observed in pellagra, beriberi, and other cases of deficiency of the vitamin B complex. The relation between this type of anemia and that of pernicious anemia is also not clear. How-

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* Read before the Pediatric Section of the California Medical Association at the sixty-seventh annual session, Pasadena, May 9-12, 1938.

† Part I appeared in the March, 1939, issue, page 184.

TABLE 7.—*Vitamin C Deficiency*

Degree of Deficiency	Clinical Signs	Incidence	Tests
Marked	Scurvy	Rare	1. Capillary resistance
Moderate	Infantile scurvy Hemorrhagic states Dental caries Anemia Increased susceptibility to infections	Unknown	2. Urinary excretion 3. Plasma levels 4. Intradermal 5. X-ray of bones 6. Therapeutic
Mild (Preclinical?)	Uncertain Above in milder form	Unknown	

ever, some factor in the vitamin B complex, but not thiamin, seems responsible for the macrocytic anemia of pellagra, beriberi and similar deficiency states.

Apparently gastro-intestinal symptoms, such as anorexia, glossitis, achlorhydria, hypomotility and hypotonicity, particularly of the small intestine, and diarrhea, are commonly associated with deficiency of the vitamin B complex. In some patients the clinical picture is characteristic of pellagra, in others it is not. Whether deficiencies of thiamin and of nicotinic acid will explain all of these symptoms is not clear.

VITAMIN C

Symptoms.

The most readily appreciated symptoms of deficiency of the antiscorbutic vitamin have to do with hemorrhagic phenomenon. This is due to the fact that the fundamental pathologic change in vitamin C deficiency is in the intercellular substance, particularly of the blood vessels, with softening of this substance which leads to hemorrhage into the subcutaneous, subperiosteal, gingival and other tissues. It has been observed that the intercellular substance, which ordinarily exists as a solid or gel, under circumstances of vitamin C deficiency may soften and become a liquid. Consequently, there has been much discussion of the possible rôle of vitamin C deficiency in acute and chronic hemorrhagic phenomena of the so-called "essential" or idiopathic type, and as to whether vitamin C deficiency may be a contributing factor in leading to hemorrhages in cases of peptic ulcer, menorrhagia, essential hematuria, subdural hematoma, and so forth. (Table 7.)

Vitamin C deficiency has also been connected with dental caries, anemia, and with increased susceptibility to infections. Most patients with infections require vitamin C in larger than usual quantities if normal levels are to be maintained in the blood and if normal quantities are to be excreted in the urine. Most observers are inclined to the opinion that this is due to the increased demand for vitamin C as a result of the infection, while others are inclined to the belief that a state of partial vitamin C deficiency may have predisposed to the development of the infection.

Diagnosis.

The clinical diagnosis of scurvy is relatively simple in a well-developed case. However, the clinical diagnosis of latent or preclinical scurvy is not so easy, although it may be suspected in patients who have unexplained hemorrhages of any type or in any situation, who have long-continued infections, or who have considerable dental caries. It is exceedingly important to emphasize that such conditions do not establish the diagnosis of vitamin C deficiency, but only suggest the possibility of it.

Fortunately, we possess better methods of determining the presence or absence of partial deficiency of vitamin C than of any other vitamin. These methods include the capillary resistence test, roentgen-ray studies of bones, intradermal test, studies of the levels of vitamin C in plasma and of the excretion of the vitamin in the urine, and vitamin C tolerance tests.

One simple method of performing the capillary resistance test in the office is to mark an area on the skin, 60 millimeters in diameter, in the anticubital fossa of one forearm. Following this, venous stasis is produced for fifteen minutes with a sphygmomanometer cuff at a pressure of 50 millimeters of mercury. If more than eight petechiae develop on the marked area the test is positive; if less than five develop, it is negative. Although this test is not specific, it is suggestive, and if positive in a case in which vitamin C deficiency is suspected, it should lead to studies either of vitamin C saturation or to treatment with vitamin C.

Methods of determining the vitamin C content of the plasma and the urine depend on the titration of these fluids with the indicator, 2–6 dichlorophenolindophenol. The titration of the urine is relatively simple and may be done in the physician's office if proper precautions are taken to preserve the urine in a dark bottle containing 10 per cent by volume of glacial acetic acid. The amount of vitamin C excreted in the urine by the normal individual in twenty-four hours is approximately 20 to 30 milligrams, while the vitamin C content of the blood plasma of the normal individual is in the neighborhood of 0.7 to 1.3 milligrams per hundred cubic centimeters of blood.

The most satisfactory method of determining vitamin C deficiency is in a measure of these levels and in an estimation of the tolerance of the patient to a test dose of vitamin C.

The diagnosis of very mild states of vitamin C deficiency depends entirely on such a chemical determination because clinical symptoms are lacking in these cases. There has been considerable discussion of the real clinical significance of such abnormal tests, for, as Finkle has pointed out, a fairly large proportion of the population suffers from an undersaturation of vitamin C. He believes that as yet there is no evidence to justify the conclusion that vitamin C deficiency has a causal relation to any pathologic condition other than scurvy.

Treatment.

Vitamin C deficiency may be avoided by intake of a diet adequate in fresh fruits, particularly of the citrus variety, and vegetables. The minimal intake necessary to prevent signs of deficiency is

TABLE 8.—*Vitamin D Deficiency*

Degree of Deficiency	Clinical Signs	Incidence	Tests
Marked	Rickets Osteomalacia	Common Rare	1. X-ray of bones
Moderate	Rickets Dental caries Inadequate mineralization of bone Tetany	Common (50-90 per cent of infants)	2. Blood phosphatase 3. Therapeutic
Mild (Preclinical?)	Uncertain (Above in milder forms?)	Unknown	

not certain, but probably approximates 20 to 40 milligrams daily.

In the treatment of deficiency the diet should be high in its content of the above-noted foods, which may be supplemented by the administration of vitamin C in synthetic crystalline form, by mouth or intravenously, in doses of from 50 to 200 milligrams. In cases with hemorrhage in which rapid saturation of the tissues with vitamin C is desired, larger doses, such as 1000 milligrams, may be given daily for two to three days and then reduced to levels of from 100 to 300 milligrams daily until the therapeutic response is complete.

VITAMIN D DEFICIENCY

Symptoms.

Vitamin D is the antirachitic vitamin which plays an essential rôle in the metabolism of calcium and phosphorus, and has to do in particular with the retention of calcium and phosphorus in the body, in the deposit of these substances in bones and, perhaps, in the concentration of these elements in the blood. (Table 8.)

Rickets is such a widespread condition in infancy (50 to 90 per cent of infants are stated to have it) that it may be classified as probably the most common deficiency disease. Vitamin D deficiency in adults may lead to osteomalacia, which is very rare in the United States. It is probable also that certain forms of osteoporosis, of tetany, and possibly of dental caries, are the result of vitamin D deficiency, either because of an inadequate diet or because of interference with absorption of the vitamin or of calcium from the intestine.

Diagnosis.

The diagnosis of rickets is usually simple. When the classical symptoms are present, the diagnosis is obvious clinically. In cases in which the symptoms are less clear-cut, the diagnosis may be suspected clinically and confirmed by roentgenologic studies of the bones. Further confirmatory evidence may be obtained by determination of the blood phosphatase, which usually is increased in rickets. The therapeutic test with the administration of vitamin D may be helpful in establishing the diagnosis.

States of partial deficiency of vitamin D may be suspected if persons have dental caries, tetany, frequently occurring fractures or osteoporosis of the bones. During pregnancy or lactation, and among patients who are jaundiced or who have abnormalities of intestinal absorption such as occur in celiac disease and sprue, deficiency of vitamin D is most likely to be present. Whether the deficiency in such cases is the result of deficiency of calcium or phosphorus, or of abnormalities in function of the parathyroid glands may be difficult to determine. The administration of vitamin D may be helpful in distinguishing osteoporosis which is on a basis of deficiency from other types of osteoporosis, but a satisfactory response does not necessarily prove that the osteoporosis is attributable to vitamin D deficiency alone.

Treatment.

While there are at least ten different sterol derivatives which exhibit the properties of vitamin D, only two of these are known to be of prime importance in medicine. These are activated ergosterol or calciferol, which is the vitamin D of viosterol, irradiated yeast and yeast milk, and 7-dehydrocholesterol, which is the chief sterol of animal fats.

Rickets may be prevented by supplying the infant each day with one of the following: (1) two standard teaspoonfuls of cod-liver oil, which meets the requirements of the New and Nonofficial Remedies (1936); (2) one quart of milk containing 400 U. S. P. units of vitamin D to the quart; (3) five drops of viosterol (1.125 U. S. P. units); (4) irradiation of the skin with ultraviolet light.

In the treatment of rickets, a dose of twenty drops of viosterol (4500 U. S. P. units) or a similar number of units of vitamin D in another form is effective. Vitamin D may be supplied also in the

TABLE 9.—*Vitamin Deficiencies*

Vitamin	Average Daily Requirement		Average Daily Therapeutic Dose	
	International units	Milligrams	International Units	Milligrams
A	4,000-10,000		25,000-75,000	
B_1	200-500	1.0-2.0*	3,300-13,000	10-40
C	800-2,000	40-100	1,000-20,000	50-1,000
D	400-1,500 [1] 4,500 [2] Unknown [3]		3,000-4,000	
G (B_2)			300-500 milligrams nicotinic acid 10-100 grams brewer's yeast 10-75 cubic centimeters dilute liver extract	

* Mg. of synthetic HCl [1] Average full-term infant [2] Premature infant [3] Child and adult

Table 10.—*Protective Foods Which Serve as a Foundation for a Normal Diet (Daily Quantities)*

Milk	1 pint
Egg	1
Vegetables	3 large servings, besides potatoes (one a green leafy vegetable)
Fruit	2 servings (one raw)
Meat, fish or fowl	1 serving (about 2 ounces)
Butter	1 tablespoonful

form of fish-liver oils, or irradiated yeast, milk and cereals, of milk to which a concentrate of vitamin D has been added or by irradiation of the skin.

In adults with senile osteoporosis, ten drops of viosterol three times daily in conjunction with four drams of calcium lactate or tribasic calcium phosphate three times daily often will relieve symptoms.

DEFICIENCIES OF OTHER VITAMINS: VITAMIN E

At least three substances possess the effect of vitamin E, but as yet it has not been clearly demonstrated that any of them is required by man for normal health or in reproduction. Of principal clinical interest is the possible etiologic rôle of deficiency of vitamin E in threatened and spontaneous abortion, and of an excess of the vitamin in malignant disease. It is difficult to obtain proof that vitamin E is of value in the treatment of sterility and habitual abortion in human beings, and much more evidence is greatly needed to establish the usefulness of vitamin E in abnormal human reproduction.

VITAMIN K

Apparently the antihemorrhagic factor, known as vitamin K, may play some rôle in the production of prothrombin, for in certain species of animals deficiency of vitamin K leads to a decrease in the prothrombin content of the blood. In considering the possible therapeutic use of vitamin K in patients with jaundice it has been suggested that it is of value because the prothrombin deficiency of such patients may be due to deficiency of vitamin K, since vitamin K is fat-soluble and there is frequently interference of absorption of fat in patients with jaundice. Vitamin K is not available on the market, but substances rich in it are green vegetables, pig-liver fat, hemp seed, and alfalfa.

USE OF VITAMINS

Use of Vitamins in Persons Who Are Chronically Fatigued, Rundown, Underweight, Below Par or Subject to Frequent Infections.

The diagnostic and therapeutic problems presented by patients who fall into this group are often very difficult to solve. It goes without saying that great care must be used to exclude the presence of an underlying organic disease when these symptoms are present, and adequately to treat it. It is probable that, of the patients who fall into this group, a certain number will present no distinguishable organic disease. Some of this latter group of patients may be benefited by administration of vitamins while other patients may not, depending on whether or not in a particular case the symptoms are due to vitamin deficiency and depending to some extent on psychic influences.

How is one to tell which patients will do well and which poorly on vitamin therapy? There is no clear-cut way to distinguish between these groups at the present time. However, the history of an inadequate diet, the presence of symptoms or findings of mild deficiency states or the occurrence of abnormal responses to some of the diagnostic tests previously mentioned may be helpful in determining the patients who may benefit from vitamin therapy.

It is important to recall that the conditions we discussing are symptoms rather than diseases, and that it is essential to treat any underlying cause of them. It is no more sensible to give vitamin therapy to all such patients and to expect good results than it is to give aspirin to all patients with headache, codein to all who cough, or opium to all who have diarrhea.

COMMENT

Finally, too much stress cannot be placed on the importance of an adequate diet in the prevention and treatment of deficiency diseases. It has been well said that the grocery store is more important than the drug store in the prevention and treatment of these conditions. In the treatment of some deficiency states, crystals and concentrates of some of the vitamins are available and, while these products are extremely useful, they should always be supplemented by vitamins in the natural state, *i. e.*, in foods, yeast, cod-liver oil, and so forth, not only because this is the way in which vitamins ordinarily are obtained by normal persons, but especially because there are present in foods certain essential substances which have not only not been synthesized or concentrated, but of which at present we are only vaguely aware. (Tables 9 and 10.)

490 Post Street.

DISCUSSION

William C. Boeck, M. D. (2210 West Third Street, Los Angeles).—I agree heartily with the substance of Doctor Wilbur's excellent paper on the very timely subject of vitamin-deficiency states.

I have been led to look upon vitamin-deficiency states of two kinds, namely, (1) clinical and (2) subclinical or "preclinical," depending upon the degree of deficiency that exists.

Clinical vitamin-deficiency states comprise the well-known group of avitaminoses with their classical, characteristic symptoms, signs and pathology. In this group we recognize such avitaminoses as xerophthalmia and hemerolopia (vitamin A deficiency); beriberi (vitamin B_1); scurvy (vitamin C); rickets (vitamin D), etc.

The suspicion that these conditions might exist in a given patient comes from a good history of an inadequate intake or absorption of food rich in the specific vitamins. These deficiency states, the clinical avitaminoses, are not difficult to diagnose, since each has its own characteristic syndrome and pathology, but there is a feeling that vitamin-deficiency states of mild degree exists, which are often not clear syndromes of symptoms and signs. These comprise the "subclinical," or, as Doctor Wilbur calls them, "preclinical" vitamin-deficiency states.

We read of the protective action of vitamins A and C against infections in general, in pneumonia, myasthenia, and treatment of rheumatoid arthritis, to immunity processes, hemorrhage, purpura, anemia, dental caries, etc.; the relation of vitamin B_1 to such conditions as anorexia, cardiac irregularities, atonic constipation, diarrhea, edema, low-serum proteins, fatigue and asthenia, anemia, lactation, growth, etc.; the relation of vitamin D to nervous irritability, asthenia, to tubercular resistance and other infections, calculi, caries, etc.; and the relation of vitamin E to sterility, impotence, miscarriage, asthenia, loss of vigor and weight, muscular atrophy, etc. One could go on almost indefinitely enumerating many other conditions which have been attributed to vitamin deficiency, until one might be almost convinced that all body ills are due to vitamin deficiency. Since the major portion of our population possesses some of the disturbances mentioned as characterizing some degree of vitamin deficiency, it is not surprising to learn that vitamin products rate fourth in value among drugstore sales, and that we appear to be in an era of a new fad—that of vitamins.

Obviously, the status of vitamins in this preclinical group of deficiency states has led to considerable confusion because of lack of (1) correct diagnosis, very often of the underlying cause, since the clinical improvement or cure which has been often erroneously attributed to the vitamin therapy, in these cases, may actually be due to some other corrected condition; (2) lack of uniform treatment of these conditions with vitamin-containing products has led to further confusion because the vitamin therapy has been variable as to method of administration, source of the vitamins used, and dosage employed in different standardized units.

That considerable confusion results from an incorrect diagnosis of the underlying functional or pathological disturbance is apparent at once. All cases of hemerolopia, or night blindness, are not due to vitamin A deficiency, for, as Frandsen and later Yudkin have pointed out, it occurs in persons with neurasthenia and hysteria, in poisoning from quinin, alcohol, nicotin, in retinitis and choroiditis, retinitis pigmentosa, glaucoma, excessive myopia, and many other conditions. Therefore, in considering treatment of persons showing hemerolopia by the biophotometer, the underlying cause must be determined.

It will do no harm to give vitamin A, since it is a food factor; but if improvement is noted it may not always be due to dietary treatment given. The ophthalmologist should also be called in to treat any underlying pathology or disturbance in visual acuity.

Again vitamin B_1 deficiency, as Cowgill states, does not explain all cases of anorexia, atonic constipation, edema, cardiac enlargement, fatigue, anemia, etc. To administer it in all such cases does no bodily harm, but it does not answer the question as to the etiology of the symptoms. One could go on with instances regarding the other vitamins, C and D, and B_2 as well, and come to realize that a correct diagnosis is the primary essential to an understanding of these cases before we can conclude they are always due to a preclinical state of vitamin deficiency.

We are handicapped in recognizing the mild states of vitamin deficiency because the clinical tests for vitamins A, B, C, and D are not available to everyone, and are based mostly on animal-growth observations, which admit of much variability at their best. There are, as yet, no well-recognized standards of value for the presence and excretion of these vitamins in normal human beings to serve as a dependable guide or basis for comparability. All this needs more investigation.

The treatment of vitamin-deficiency states, both clinical and preclinical, has caused more confusion: first, as to method of administration, by mouth as part of the diet rich in the particular vitamin, or parenterally by use of the purified product. For example, from 10 to 100 milligrams daily of thiamin chlorid have been used to cure polyneuritis of B_1 deficiency, but no one has shown how much is necessary; and large doses, while effective, may be too expensive at present for many patients.

The confusion has been added to by the fact that all vitamin products on the market, while purporting to represent so many units per gram, or cubic centimeter or tablet, are often deficient when subjected to animal-assaying procedures of standardization. This may be due to factors that are uncontrollable because animals are used, and because the United States Pharmacopeia reference standards may not yield all the vitamins they are supposed to yield. The purified vitamins will, doubtless, prove to be better reference standards in the future, but Williams feels that in the case of vitamin B_1 it will be difficult to find a satisfactory method of chemical assay, since it possesses no known physical property which is adopted to delicate testing. Better United States Pharmacopeia reference standards to determine vitamin units would also do away with the confusion still existing in reference to the labeling of these vitamin concentrates in different kinds of units; this practice, however, is becoming less prevalent.

May I summarize by stating: (1) That the clinical types of vitamin deficiency, the classical avitaminoses, are not difficult of diagnosis and treatment, because of their characteristic symptoms, signs, and pathology, although the matter of correct dosage is still obscure; and that (2) the "preclinical" types are difficult of diagnosis, because the symptoms are also those of other functional or pathological disturbances, and hence vitamin concentrates may be given, but often unnecessarily. This leads to confusion, but produces no bodily harm, although the patient may suffer an unnecessary financial relapse since vitamin products are expensive. (3) It is hoped that the future will provide beter methods for the detection of these preclinical vitamin-deficiency states, since the present methods of detection are not available to all, and are not based upon accurate standards. Then experimental and therapeutic procedures will be far more comparable, and therefore more valuable, because of uniformity of the source, dosage, and administration of the vitamin products. (4) Let us all keep in mind the substance of Doctor Wilbur's Tables 2 and 3, which afford a most excellent guide to the question of when we may suspect a state of vitamin deficiency, because if this guide is followed much unnecessary vitamin administrations will be avoided.

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Albert H. Rowe, M. D. (490 Post Street, San Francisco).—The various manifestations and possible results of a deficient vitamin intake, so well discussed by Doctor Wilbur in his article, necessarily should be in the minds of all physicians in the study and treatment of patients, for avitaminosis is possible in any individual. Doctor Wilbur's emphasis of the mild or subclinical results of deficient vitamins is especially timely. The fact that absorption of vitamins naturally occurring in food, and of those administered orally, may not be adequate for metabolic requirements, must be appreciated. Because of this, the increasing accuracy of clinical and laboratory tests, discussed by Doctor Wilbur, which reveal probable deficiencies in the important known vitamins in the body, offers valuable information which makes possible proper dietary adjustments and indicated supplemental vitamin therapy. In the endeavor to protect all patients against vitamin and other dietary deficiencies, every history should contain information concerning the past and present habits of diet. In such dietary history, the average amounts of foods of all kinds and types taken during previous decades, and during the past few years, allow a rough, though clinically valuable estimation of the intake of necessary vitamins throughout life, and the likelihood of protein or mineral deficiencies which may have contributed to chronic or present symptomatology. Such a diet history, moreover, should record detailed information concerning possible food dislikes or idiosyncrasies which suggest possible mild or more severe food allergies.

Of great help in the determination of the vitamin content of a diet is the tabulated number of units of vitamins A, B_1, B_2, C, and D in 100-gram amounts of most foods assembled by the United States Department of Agriculture in 1937, as reported in Bulletin A-275. The units of the various vitamins have been determined by many investigations and experimental studies, and offer approximate though practical information. With the daily average requirements of the vitamins known, as listed by Doctor Wilbur and as published elsewhere, it is usually possible to arrange the diet so that proper amounts of ordinary foods can satisfy the vitamin demand of the body. Frequently, additional vitamin therapy, especially with vitamin D, is required, especially if long-existing deficiencies have been present. Such assurance of adequate vitamins in the diet, as well as of minerals and proteins, is especially necessary when the diet must be modified because of metabolic, allergic, gastro-intestinal, or other diseases. This is particularly important in the use of elimination or test negative diets for the study or control of food allergy, in which absolute assurance of adequate vitamins, proteins, minerals, and calories to satisfy the patient's nutritional requirements is mandatory.

THE LURE OF MEDICAL HISTORY†

TRUTH OVERTAKES "DOCTOR HUNTER"

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PART III*

WILLIAM'S MEDICAL COMMENTARIES

While in the Army Medical Library some months ago, I had opportunity to consult a reference in William's *Medical Commentaries* to which my attention had been directed by our departmental secretary, Miss Miner, who had found it in Haller. The page to which Haller referred carried a footnote, which would have required more than a page of space if printed in the same-sized type as the text, and accompanied a discussion "Of Absorption by Veins." In this note, William wisely emphasized a certain unreliability of injection methods, but, nevertheless, seemed to feel that they were entirely dependable in his hands and in those of Noortwyck, as contrasted to those of the Monros—*primus et secundus.* Before proceeding with the footnote it is well to recall the following comment from Paget about the Commentaries:

> . . . In 1762, the year John was in the Peninsula, William Hunter published his "Medical Commentaries. Part I": surely one of the strangest books that a physician or a surgeon ever wrote. From beginning to end, it is an incessant attack on those who discovered what the brothers also discovered; every device of italic type, notes of exclamation, and long quotations, interrogation and interjection, heavy sarcasm, charges of stupidity, falsehood, and flagrant theft—all these things make the book, and there is nothing else in it, hardly one line that is quiet. It was the method of controversy fashionable in his time, full of sound and fury. The points at issue lay between the brothers on the one side, and the Monros of Edinburgh on the other side; and to these disputes was added a controversy with Percivall Pott. The claims and counterclaims must be put here; but this is not the place to decide, even if it were possible, between the disputants.[15]

It is quite incorrect to say that there are nothing but disputations in the Commentaries. The footnote on page 52 alone shows this, and had Paget not overlooked or disregarded it he could not only have given a juster statement of the "claims and counterclaims," but would have settled a matter so long and so painfully at issue.

It was to the above page (52) that Haller had wisely referred when considering the idea of William, regarding the distinctness of the utero-placental circulations; for, instead of finding confirmation of this idea there, exactly the opposite is maintained in words that are truly surprising. The following is a verbatim copy:

> Anatomical injections have certainly improved physiology, and yet they have sometimes led anatomists into great blunders. From the simplicity of the art of injecting, any man who can fix a pipe and melt wax, may set about experiments of that kind, and may draw conclusions about the delicate and complex operations in the living body, from the event of a blundering experiment made upon a dead one. If his wax breaks through the vessels at any part, it will be a *direct proof* that there was a natural passage; and if by escaping at this *ready outlet*, it does not run into the smaller vessels, it proves clearly that no such small vessels exist, and that those anatomists who have seen them, and who have injected them, must have mistaken one thing for another. Our young Professor is one of those who make bold injections and bold conclusions. His father has the same pretensions to injections, and has the same knack of going on in the argument, whether the wax stops or runs. I shall give a specimen. He twice, in a bitch, injected the uterine vessels with mercury, and found that he had not thereby filled any vessels in the *placenta*; thence he concludes that in that animal the uterine vessels do not ramify through the *placenta*: and yet I find it as easy to prove by injections that they do, as that the mesenteric vessels go into the coats of the intestines. Having in this way established his supposition, that the uterine vessels do not in the human subject pass into the placenta and chorion, he afterwards found it would be necessary in support of his opinion to take off Noortwyck's authority, and therefore tells us that Noortwyck must have made *a mistake,* and is persuaded he will alter his opinion, *when the mistake is pointed out to him*; and, what is still better, concludes that Noortwyck *has afforded him a very pretty proof of there being no anastomosis between the vessels of the uterus and fecundines.* Professor Monro would only have you suppose that Dr. Noortwyck had mistaken the *uterus* for the *placenta* and membranes, and, in order to give his argument some plausibility, he has *egregiously misrepresented* the Doctor by substituting *one* word for *another* of a quite different meaning, in two of his quotations, and in a third has *coined a whole sentence* for him; etc. etc. Now the fact is, that Noortwyck was not mistaken, and is, we may presume, of the same opinion still, as it is impossible he should not believe his own eyes. I have seen his preparation, and can vouch for the truth of the greatest part of what he advances, not only from having seen that preparation, and from having conversed with him upon the subject, but *from my own experiments and observations on the human uterus, and those often repeated.*[16]

COLE'S COMMENTS

Here, then, is William in 1762 still insisting that the fetal and maternal circulations are continuous, yet as Cole said:

> In the description of his plates of the gravid uterus, published posthumously in 1794, William Hunter states he first injected the vessels of the fœtal placenta from the navel string in 1743, but it was only when the plates were first issued in 1774 that this experiment was described. He says that he injected the placenta with wax of different colours—the uterine arteries red and the veins blue, but none of the injection mass passed into the vessels of the navel string. In the 1794 publication further details are added. The placenta of man and quadrupeds, he remarks, is composed of two parts intimately blended—a fœtal element, which is the continuation of the umbilical vessels of the fœtus, and a maternal, which is an "efflorescence of the internal part of the uterus." . . . When the second Monro and William Hunter were students, it was still believed that the maternal blood circulated through the fœtus by the navel-string, and returned to the parental vessels, in spite of the positive demonstration to the contrary by the first Monro. Hunter's belief in injection methods was deeply strengthened by his visit to Albinus in 1748, when the beautiful preparations of the Leyden Professor fired the imagination of the Scots anatomist.[17]

WILLIAM HUNTER'S CONTENTIONS

Since William claimed that he had discovered the discontinuity of these circulations by injections made before 1754, it must surprise everyone that he now (1762) believed that they were continuous not only because of what he had seen of Noortwyck's injections but ". . . *from my own experiments and observations on the human uterus, and those often repeated,*" apparently made before 1754.

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† A Twenty-Five Years Ago column, made up of excerpts from the official journal of the California Medical Association of twenty-five years ago, is printed in each issue of California and Western Medicine. The column is one of the regular features of the Miscellany department, and its page number will be found on the front cover.

* Part I of this paper appeared in the issue of February, 1939, page 120, and Part II in the issue of March, 1939, page 199.

[15] *Ibid.*, pp. 56, 57.

[16] Hunter, William: Medical Commentaries. Part I. Chapter on "Of Absorption by Veins," p. 52.

[17] Cole, F. J.: The History of Anatomical Injections. Studies in the history and method of science, edited by Charles Singer. Pp. 333, 334. Oxford, 1921.

How very confusing this whole situation has been to those not familiar with this footnote is well illustrated by Teacher's (1900) statement that ". . . it is unreasonable to suppose that they [the injections] were figured then [1750], yet only understood in 1754,"[18] and by Garrison's statement that William's ". . . special discovery of the . . . separate maternal and fetal circulation, in which his brother had a part, is the foundation of modern knowledge of placental anatomy."[19]

One, unfortunately, cannot plead forgetfulness in defense of William. Although eighteen years had passed between the publication of the above footnote in the *Medical Commentaries* and the writing of his letter to the Royal Society, the topic long had been a live one. If it be true, as Cole implied, that William came to London believing in the unity of the uteroplacental circulations, the footnote of 1762 suggests that he probably continued to hold this view up to then. This is in accord with John's claim and also with the lecture notes of professed students of William. Moreover if, as stated to the Royal Society, William gave John "... all the little anatomical knowledge I could communicate" and that he actually had always treated the idea as his discovery in his lectures, John would have been aware of it and William could not have expressed himself as he did in 1762. However, he must have changed his mind between 1762 and 1766, although the "Gravid Uterus" of 1774 is ample proof that he did not even then care to assert what he so stoutly maintained in 1780 he had discovered before 1754!

I have always had the highest regard for William's abilities and accomplishments. His two excellent lectures on the history and value of anatomy, introductory to his last course, can well serve as a timely lesson to young men who wish to enter the field of surgery today. That he once thought well of Monro, Senior, is attested by words from his letter to his brother "Jamie." According to Paget (p. 40), he wrote: " . . . I cannot learn why you throw Monro out of your scheme. I really think his a good course, and so fit for you that I would by no means have you neglect it, except you cannot otherwise attend enough to pharmacy and surgery which are truly the chief points." But one is amazed to learn that he is said to have declared " . . . most philosophers, most great men, most anatomists, and most other men of eminence lie like the devil." He, himself, apparently did in one instance, and much to the discomfiture of John and the confusion of others. If his conduct will remind those who have followed in his errant footsteps that some time, somehow, Nemesis may yet catch up with them also, his sad example may continue to bear good fruit.

Paget said that one looks in vain for "some sort of an excuse" for John's ". . . astonishing communication to the Royal Society . . . and finds only such gossip as makes it worse. . . . We are still left wholly unable to see why he waited twenty-six years and then, when he was fifty-two years old, raised a storm over a dissection that he had made when he was twenty-six"; and, according to Garrison (1921): "Later in life, for some private or personal reason, he picked a public quarrel with the brother who had formed him and made a man of him, basing the discussion upon a quibble about a priority entirely unworthy of so great an investigator." John obviously did not raise a storm over a dissection, but over a discovery, and such a criticism in a deservedly popular history of medicine as that of Garrison not only blots the character of John and calls truth-telling quibbling, but publicizes and perpetuates untruth. Is it not possible that John, fully aware of William's true opinion as stated in the footnote of 1762, continued to believe that it was he who had made the discovery and, hence, felt that he owed something to the truth? Certainly everyone who values facts must be grateful to him for his candor, for otherwise we are forced to conclude that, after all, history is nothing but "bunk" as a well-known industrialist is reported to have said, or "lies" as a foremost American historian had previously declared.

John's claim not only has been distrusted but his delay in advancing it publicly has been criticized adversely. It should be recalled that he came to his brother as an untutored and unsettled lad, when the former was an accomplished anatomist and physician of high standing, only six years before the time John claimed to have made the discovery. Since the announcement of it to William was received by the latter with raillery, John may well have hesitated to make a public declaration at that time, out of deference to the opinion of his learned brother. Although John himself may not have attended the lectures of William in those years, he must have been greatly perplexed and perturbed by what those who did attend then reported and recorded regarding his brother's attitude on the question of the uteroplacental circulation. It is obvious that the time was right for action by John after William had written the footnote of 1766, but since John knew that the *Gravid Uterus* had long been in preparation, he may have felt constrained to await its publication because his brother might reiterate his erroneous idea there or else credit him with having advanced the correct one in 1754. The great acclaim accorded the publication of this unsurpassed atlas clearly made that time inopportune, but when a few years later the health of William began to fail, it was necessary for John to act in order to escape the onus of making his claim posthumously. Hence his communication, "On the Structure of the Placenta" to the Royal Society in 1780, only three years before the end of his brother's life and thirteen before his own.

IN CONCLUSION

I have called attention to this footnote not merely to exonerate John, but to reveal the truth as contained in the words of William, himself. It is perplexing how words which so seriously indict him and so effectively nullify his contention could have been overlooked or disregarded so long. Surely, "Une page de l'histoire ne doit pas être salie," and since William was the first so to soil it, it is fortunate that the page can be restored definitively by his own words.

Department of Anatomy.

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[18] Teacher, John H.: The Anatomical and Pathological Preparations of Dr. William Hunter. Introduction. Glasgow, 1900.

[19] Garrison, Fielding H.: An Introduction to the History of Medicine, pp. 347, 354. Third edition. Philadelphia, 1921.

CLINICAL NOTES AND CASE REPORTS

A TRANSFIXATION PIN FOR CANCELLOUS BONE

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A SIMPLE and easily constructed transfixation pin is here reported which proved very useful in a fracture of the lateral condyle of the femur with upward and backward displacement.

The need for an open reduction in this type of fracture is well recognized, for only by an accurate replacement of the articular surfaces is it possible to obtain a perfectly functioning knee. Various screws, nails, bolts, etc., have been advocated in the past for fixation of this displaced fragment; however, it was not until recently that one was able to secure these in a metal that would not produce a foreign body reaction when buried in the tissues. Because of the closeness of this fracture to the joint, this factor is very important.

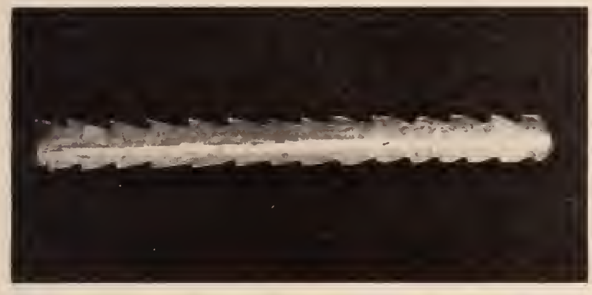

Fig. 1

Fig. 1.—Right angle stainless steel pin used in this case, photographed after removal.

"Eighteen and eight" stainless steel has been proved to be well tolerated by the tissues, and is now universally used in fracture work. With this knowledge, and because of the difficulty in obtaining the desired type of transfixation pin in this metal, the author was compelled to construct one himself. This was easily accomplished by obtaining a sheet of twenty-six gauge "eighteen and eight" (stainless steel) from the local sheet-metal shop, cutting off a strip about two and a half inches long and three-eighths of an inch wide, and bending this lengthwise at a right angle. The edges were then notched with a small triangular file. The end was slightly pointed and sharpened. A very sturdy pin resulted which, by its shape, could easily be driven into cancellous bone without much displacement of it and which, due to its right-angle surfaces, would make impossible rotation of the fragments upon each other, with the irregular edges preventing the pin from slipping backward. (Fig. 1.)

REPORT OF CASE

Case 1.—F. M., male, age twenty-four. Referred from Dr. Charlie M. Mathias of Tulare for a fracture of the lateral condyle of the left femur. Open reduction was performed on February 14, 1938, the fragment being exposed by a posterior lateral incision. The joint was opened and the lateral condyle of the femur was found to be pushed upward and backward. The external semilunar cartilage had been displaced medially into the joint, and its mid-portion was lying between the fragments. The semilunar cartilage was excised. The fragment was then replaced and the described transfixation pin driven through it into the opposing bone structure until the base of the pin was even with the bony surface. The fragment was found to be then solidly fixed into the desired position. The wound was closed in layers and a knee plaster applied. The postoperative convalescence was uneventful. Postoperative x-rays did not show, at any time, evidence of a reaction about the fixation pin. At the end of four months, the pin was exposed through an incision one and a half inches long and removed without difficulty by grasping its edge with a pair of pliers. The tissues showed no reaction about the pin, and the pin itself was as "shiny" as when it was inserted. The postoperative recovery was uneventful. Preoperative and postoperative x-rays are illustrated. (Figs. 2 and 3.)

SUMMARY

A simple and easily constructed, nonirritating transfixation pin is reported which proved to be of value in a fracture of the lateral condyle of the femur.

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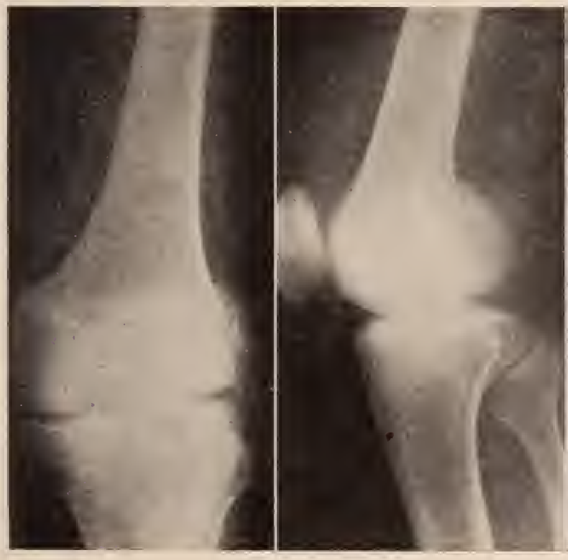

Fig. 2

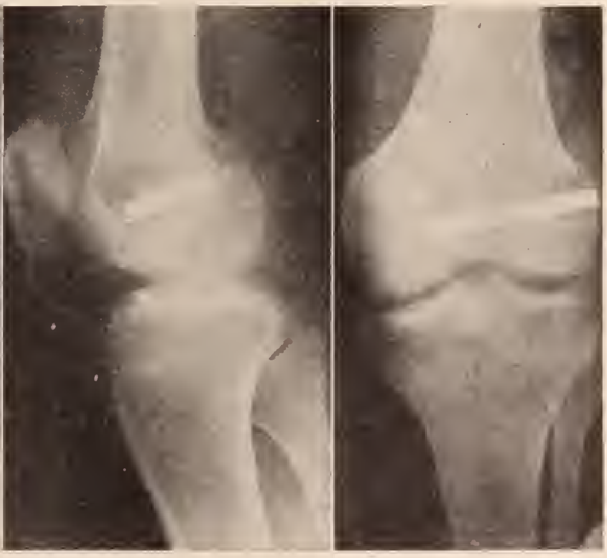

Fig. 3

Fig. 2.—Preoperative x-ray showing fracture of the lateral condyle of the femur with upward displacement.

Fig. 3.—Postoperative x-ray, taken three months later, showing the reduction and fixation secured by the pin described.

SUBPERIOSTEAL CALCIFICATION AND BONE-CHANGES IN EARLY SCURVY*

By Carl D. Benninghoven, M.D.
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Early scurvy is sometimes confused with a suspected fracture by the clinician, but can be differentiated readily by x-ray films of the long bones. Most of the typical changes have been described in the monograph by Park, Guild, Jackson, and Bond.[1] These early classical roentgen signs are (1) a dense calcified lattice, (2) a zone of decalcification proximal to the lattice, (3) a cleft or crevice at the distal corners of the shaft, and (4) slight bagging at the distal margins of the shaft. These authors consider subperiosteal calcification a late roentgen sign of the disease. They also point out that these early roentgen signs are best demonstrated in postero-anterior studies of the wrists and knees, and lateral studies of the ankles. The distal ends of the ribs show the changes first; but these areas are difficult to x-ray satisfactorily.

The three cases presented show early clinical and roentgen signs of scurvy. The first case is atypical because of extensive subperiosteal calcification prior to the development of typical early roentgen signs in the diaphyses of the long bones. All three cases demonstrate the delay in the clinical relief of symptoms while under adequate antiscorbutic treatment, the delay of weeks before the bone changes due to scurvy are healed, and of several months before new bone has replaced the subperiosteal calcification.

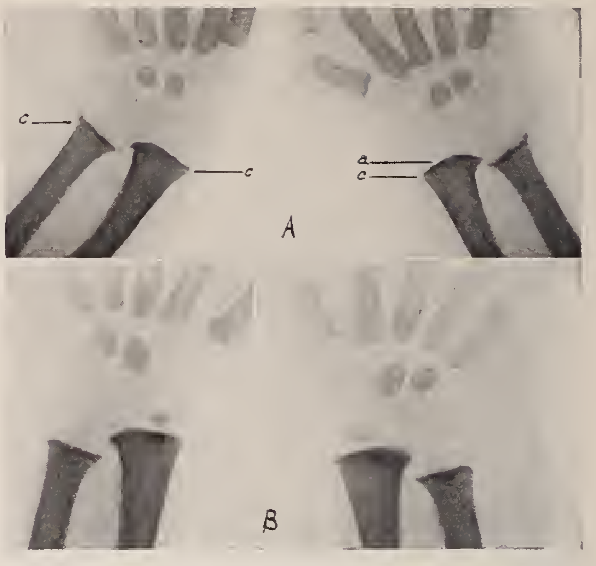

Fig. 2 (Case 2).—*A*, wrists; *a*, dense calcified lattice; *c*, clefts at distal ends of shafts. *B*, six months later, normal.

REPORT OF CASES

Case 1.—W. C., a white, well-nourished male infant six months of age, who was referred on August 19, 1937, for examination of his left forearm for question of fracture. No fracture was seen in the x-ray films. The subperiosteal calcification and mottling in the cortex of the ulna suggested periostitis and osteomyelitis. The arm was put at rest, but the swelling and pain increased. On August 26, 1937, the subperiosteal calcification had increased and the temperature was 101 degrees rectally. The blood count was 24,850 white cells, with polymorphonuclear neutrophils 54 per cent, small lymphocytes 34, large lymphocytes 3, myelocytes 5, eosinophils 1, red blood cells 4,930,000, and hemoglobin 60 per cent. The ulna was needled, but only blood was withdrawn. This blood was negative for bacterial growth on culture media. On August 27, 1937, a purplish swelling developed under the left eye. A day later the right infra-orbital space was purplish. A blood culture was negative. At this time x-ray films of the left radius and left femur showed subperiosteal calcification and typical signs of scurvy at the ends of the diaphyses. A diagnosis of scurvy was made. The vitamin C of the blood as

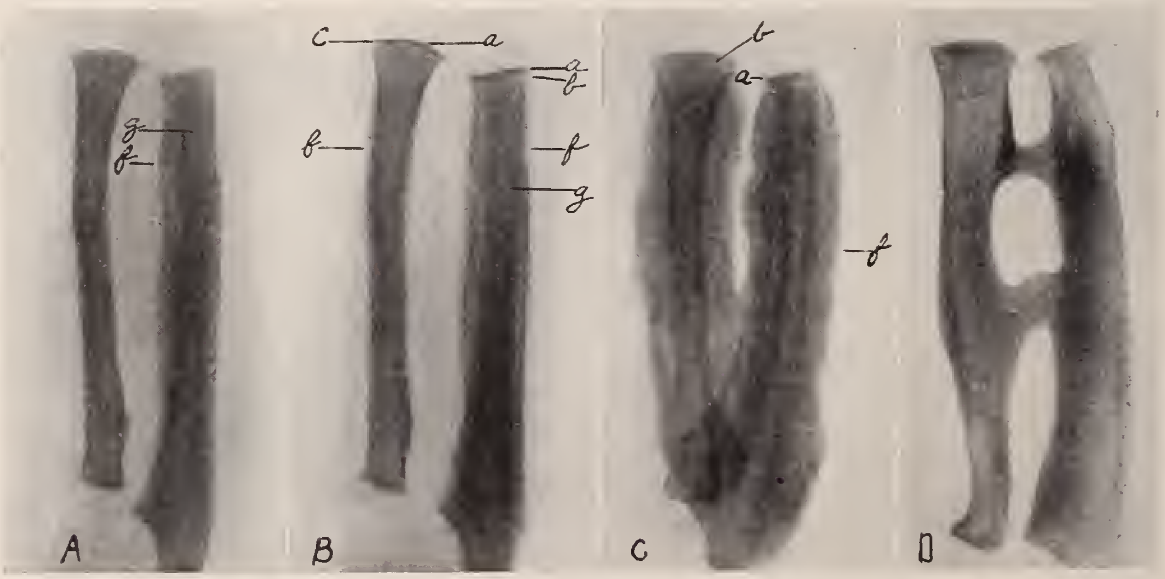

Fig. 1 (Case 1).—*A*, left forearm on August 19, 1937; *g*, cortex thin and granular; *f*, subperiosteal calcification. *B*, seven days later; *a*, dense calcified lattice; *b*, zone of decalcification; *c*, cleft at distal end of shaft; *g*, cortex thin and granular; *f*, subperiosteal calcification. *C*, twenty days later, subperiosteal calcification has increased, the zone of decalcification is less prominent and the calcified lattice is less dense. *D*, four months later, the cortex is thickened and a synostosis is present between the radius and ulna.

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* Read before the Radiology Section of the California Medical Association at the sixty-seventh annual session, Pasadena, May 9-12, 1938.

[1] Park, Guild, Jackson, and Bond: "The Recognition of Scurvy, with Especial Reference to the Early X-ray Changes," Archives of Diseases in Childhood, 9-10:265-294, 1934-1935.

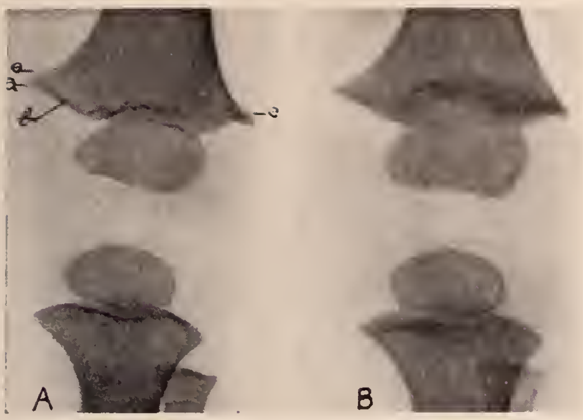

Fig. 3 (Case 3).—*A*, right knee; *a*, dense calcified lattice; *b*, zone of decalcification; *c*, bagging at margins. *B*, right knee normal four months later.

reported by Dr. James F. Rinehart was 0.24 milligram per cent. The leukocyte count remained between 24,000 and 36,000, and the temperature remained between 100 and 102 degrees rectally. Orange juice and 150 cubic centimeters of cevitamic acid were administered daily without improvement. The cevitamic acid in the diet was increased to 300 cubic centimeters daily. After sixteen days of vitamin C therapy the patient's symptoms improved. The x-ray films showed an increased amount of subperiosteal calcification. The calcified lattice was still present, and the decalcified area proximal to the calcified lattice was easily recognized. The cortex was thin and granular. As symptoms subsided, the appearance of the bone changed. The cleft or crevice was repaired. The calcified lattice became less prominent. The subperiosteal calcification decreased in amount and density. A line of increased density remained in the shaft indicating the period of arrested bone growth. The cortex remained thicker than normal.

* * *

Case 2.—N. L. A., a well-nourished Italian girl, eight months of age. The patient was referred because of pain in her left femur on motion. The parents stated the child had fallen from a bed a few days previously. X-ray films were interpreted as showing moderately early roentgen signs of scurvy. A calcified lattice was clearly defined. There was a decalcified area proximal to the lattice, and a cleft or crevice at the margin of the diaphysis. No subperiosteal calcification was present. Symptoms disappeared in seven days, with a diet of orange juice. X-ray films made four months later were interpreted as showing improvement, but not complete disappearance of the roentgen signs of scurvy. There was some question as to faithfulness in administering the orange juice. Six months later the bones were normal in appearance.

* * *

Case 3.—J. R., a well-nourished white female, one year of age. The patient was referred because of pain in her leg, which was thought to be due to a fracture. Interpretation of the x-ray films of her legs showed the typical calcified lattice at the ends of the shafts, the zone of rarefaction at the distal margins, and the slight bagging at the lateral distal margins. The clinical symptoms disappeared after a week's feeding on orange juice. Films taken three months later were interpreted as showing complete disappearance of the roentgen signs of scurvy.

CONCLUSIONS

1. X-ray is a positive early method of diagnosis in infantile scurvy, and a method of differentiating suspected fracture.

2. Subperiosteal calcification may precede typical scurvy changes in the diaphyses of the long bones.

3. Several days to weeks are required before symptoms of scurvy are controlled by adequate antiscorbutic diet.

4. Several months must elapse before the subperiosteal calcification is completely absorbed or formed into new bone.

Mills Memorial Hospital.

The author wishes to express his appreciation to Drs. Erma Macomber, Ernest W. Cleary, Milton Novotny, and F. Holmes Smith for the loan of the clinical data.

THE GRAD FROM TIMBUCTOO [*]

The medical texts are covered with dust,
Neglected and musty they stand;
And the compound 'scope is red with rust,
And the journals mold, near at hand!

Time was when the favorite texts were new
And the 'scope had its daily water;
'Twas then that the Grad from Timbuctoo
Left school—and put them there.

"You'll be right here when I've time," he said,
"And after my rounds are through!" . . .
Then he hurried off, at last, to bed
And dreamt that his plans came true.

But as he was dreaming, an urgent song
Woke the Grad from Timbuctoo . . .
The work came thick, and the money fast,
He had all that he wished to do.

And always waiting, right close at hand
While the dust and the rust grew more,
Were texts and journals and microscope
With the latest of medical lore.

Aye, faithful to Timbuctoo they stood
Each in its given place—
Just waiting the touch of a searching mind,
And the smile of a willing face.

They wondered as waiting the long years through
In the dust, without any care,
Why that Grad from Timbuctoo
Ever got them and put them there!

Then gradually, as the years slipped by,
The Grad felt his prestige fall,
And he realized with a sudden pang,
That he hadn't "kept up" at all;

He looked askance at the rust and dust
And the stack of journals high,
And he knew in his heart he'd never catch up
No matter how hard he'd try!

Are *you* like the Grad from Timbuctoo
Who failed in its standards high?
Will you, as the years go racing along,
Let the chance to "keep up" slip by?

If so, you'll wonder, while sitting alone
In the dear old office chair,
Why other doctors are busy as heck
And you are just sitting there!

Unsafe Rabies Vaccination Method.—The single injection method of vaccinating dogs against rabies is unreliable and should not be depended on, Benjamin F. Hart, M.D., and Elwyn Evans, M.D., Winter Park, Fla., report in *The Journal of the American Medical Association* for February 25.

They cite a patient of theirs, a white man, aged 41, who was bitten on the upper lip by a neighbor's dog while attempting to retrieve his own dog during a fight. Because both dogs had been vaccinated against rabies six months previously, by the single inoculation method, he did not consult a physician.

Twenty-two days later the symptoms of rabies appeared and twenty-four hours later a physician was called because of a "mild digestive upset with vomiting and a generalized headache." Since there is no known specific drug for clinically developed rabies, sulfanilamid was tried but it did not halt the progress of the disease. The man died.

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[*] William J. Kerr, M.D., of San Francisco, in his postprandial talk on postgraduate training, at the one hundredth semi-annual meeting of the Southern California Medical Association, added to the entertainment of the dinner guests by giving these verses, penned by a member of his family, Dorothy Fisk Kerr.

BEDSIDE MEDICINE FOR BEDSIDE DOCTORS

An Open Forum for brief discussions of the workaday problems of the bedside doctor. Suggestions of subjects for discussions invited.

ENURESIS

ETIOLOGY

Charles Pierre Mathé, M. D. (450 Sutter Street, San Francisco).—Enuresis has received many definitions. It consists of involuntary or unintentional nocturnal or diurnal urination, usually not associated with uropathy. We prefer to define enuresis as an incontinence of urine which, as a rule, is functional in origin, but sometimes associated with general disorders, neurologic disturbances, pollakiuria and pathologic lesions of the genito-urinary organs. The age at which a child learns to control micturition varies with training, mentality and heredity. Diurnal incontinence of urine is usually considered to be normal up to the age of one, and nocturnal incontinence up to the age of two years, after which vesical control should have been accomplished.

The etiology is ordinarily psychic in nature; however, it may accompany general disorders, severe illnesses, neurologic disturbances of the reflex-nerve centers of the cord, or pollakiuria, or may be due to congenital and acquired pathologic lesions of the genito-urinary tract. The presence of blood, pus and organisms in the urine calls for a complete urologic examination. Urologic investigation is indicated in patients in whom symptoms persist longer than three months, despite medical care consisting of psychotherapy. In a large percentage of these cases the underlying pathologic lesion of the genito-urinary tract will be disclosed, permitting the physician to institute proper treatment and thereby obtain permanent relief.

In order to understand the etiology of enuresis it is well to review briefly the complex mechanism of normal urination. When the bladder is filled with urine increased intravesical tension sets up rhythmic contractions of the bladder wall which send afferent impulses to the centers of urination in the sacral cord. These stimuli excite contraction of the bladder wall and relaxation of the sphincter. This is a simple automatic reflex and exists in all infants up to the age of two or three years. After this age the afferent impulses going to the cord also ascend to the cerebrum, and the individual either performs the act of urination voluntarily or inhibits the act by contracting the external sphincter. In voluntary urination there is synchronization of muscular action of the bladder which consists of contraction of the bladder muscle and relaxation of the sphincter. In addition, urination is augmented by contraction of the abdominal muscles. In enuresis the inhibiting cerebral action is lost and micturition takes place by simple spinal reflex through visceral afferent impulses.

The etiology of enuresis has received considerable attention since the days of antiquity, and we find the names of Paulus Aegineta, Galen and Avicenna and, in later years, those of Cooke, Trousseau, Guyon, and many others associated with it. In recent years many writers restrict the term enuresis to the so-called uncomplicated psychic cases in which no organic etiology is demonstrable. We concede that a greater percentage of patients presenting enuresis are medically negative; however, there is a certain group of patients in whom involuntary discharge of urine, after the second year of life, is due to pathologic diseases of the genito-urinary tract, to general disorders, to severe illnesses, to neurologic disturbances and to pollakiuria. Most internists, pediatricians and psychoanalysts emphasize the psychologic type; urologists who are called upon to solve the etiologic mystery, when suggestion, training and other methods of treatment have failed, often find a pathologic lesion of the genito-urinary tract which is responsible for incontinence. It is our purpose to consider all the etiologic factors present, thereby enabling the general practitioner to more intelligently study this condition and institute adequate treatment.

1. *Psychic Type of Enuresis.*—This is by far the most common type. It is the consensus of opinion that the psychic group comprises 95 per cent of children presenting enuresis (Mowrer and Mowrer). Most children acquire vesical control during the day at the end of the first year, and control during the night at the end of the second or third year. After the third year the strictly reflex subcortic neural mechanism of automatic emptying of the bladder persists. In this type heredity plays a great factor, and one often observes enuresis in many members of the same family. It is worse in cold weather and during periods of excitement. It is not uncommon to observe enuresis develop in children in whom the urinary control had previously been established during the second year. In these recurrence takes place between the ages of four and eight; in some cases the child begins to wet the bed earlier, in others, later. Incontinence may be intermittent, but it rarely occurs after the age of ten. Psychologists explain this psychic phenomenon on the basis of behavior patterns. The child may feel that he is being neglected and, therefore, revenges himself on his parents by wetting the bed in order to attract attention. These children often twitch, refuse food, steal, run away and sometimes also present fecal incontinence. Some of these children deliberately ingest water before bedtime in order to induce enuresis. Psychologists point out the rôle of urethral irritation due to masturbation, and even go so far as to claim that in some patients a

certain amount of libido is experienced in the act of urination. If the psychic type of enuresis is unarrested, it may lead to psychopathic pollakiuria in later life.

2. *Enuresis Accompanying General Disorders.* One can readily understand why incontinence occurs in patients presenting diabetes, in whom increased urinary secretion requires more frequent emptying of the bladder. Enuresis sometimes accompanies typhoid fever, pneumonia and other debilitating infectious diseases. It is not uncommon after trauma. I recall a small Chinese boy who fell from the roof of a two-story building and, although no severe injury was sustained, the little patient developed enuresis which lasted for considerable time. This type of enuresis, associated with general disorders, develops after vesical control has been established at the usual age of two or three.

3. *Neurological Type of Enuresis.*—Enuresis is caused by certain diseases of the spinal cord in which there is a lesion of the afferent and efferent nerves concerned in the reflex act of urination, such as injury to the cord in the region of the reflex urinary center, spina bifida, cord tumor, transverse myelitis, hematomyelia, etc. It is interesting to note in passing that a patient, who had suffered from enuresis due to long-standing spina bifida occulta, was relieved by resection of a band of fibrocartilagenous tissue which compressed the dural sac of the nerves of the cauda equina. Many have devoted attention to atony of the external sphincter that is often present. This is ascertained by the passage of a bougie à boule into the bladder and, failing through that procedure, to encounter the usual resistance due to the constricting action of the external sphincter. Many of these patients sleep quite soundly, and it is even difficult to arouse them with an alarm clock. In these deep-sleeping patients the intercommunicating inhibiting action of the medullary centers is lost, contraction of the external sphincter does not take place, and immediate emission of urine results. In ascertaining the etiology of enuresis one must always bear in mind the possibility of congenital and acquired neurologic lesions of the cord as a cause of paralysis of reflex-micturition sensibility.

4. *Etiologic Rôle of the Pathologic Lesions of Genito-Urinary Organs.*—Congenital and acquired diseases of the genito-urinary tract are responsible for enuresis in a greater percentage of children than is usually conceded. In a recent review of 249 children, subjected to a complete urologic study, in whom enuresis had not been relieved by medical treatment including psychotherapy, Campbell disclosed underlying organic disease in 60 per cent. The importance of genito-urinary disease as an etiologic factor is well understood by the urologist, as he is called upon to solve the etiologic problem when medical treatment has failed. It is unfortunate that many medical men underestimate the rôle of uropathy as an etiologic factor of enuresis; for it is found to accompany cystitis, pyelitis, nephritis, vulvovaginitis, and urethritis. Thomas called attention to the rôle of verumontanitis, and reported relief by fulguration of the enlarged and congested verumontanum. It is also associated with tuberculosis, vesical calculus and, more rarely, with tumors of the bladder. In these infectious lesions, careful examination of the urine will reveal the presence of pus, blood and the infecting organisms, and when these are encountered one should proceed with a complete urologic investigation. Balanitis, phimosis, and adherent prepuce have been considered as etiologic factors. However, their rôle is doubtful, as questionable results have been obtained by circumcision. Then we have the congenital anomalies which play a great rôle in enuresis, *e. g.*, congenital stricture of the meatus, hypospadias, epispadias, ectopic kidney, anomalous ureteral orifice, megalo-ureter, hydronephrosis, diverticulum, etc. Valves of the posterior urethra, and congenital and acquired median bar, often cause incontinence on account of retention that they produce.

5. *Enuresis Associated with Pollakiuria.*—Many years ago Dieulafoy coined the word "pollakiuria" to describe frequent, urgent and painful urination. In patients suffering from this type of irritable bladder, no definite organic abnormality is encountered. Enuresis accompanying pollakiuria occurs in childhood as well as at all ages. This syndrome is unusually resistent to treatment, and symptoms often continue on through adult life.

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SYMPTOMATOLOGY AND PATHOLOGY

Adolph A. Kutzmann, M. D. (1930 Wilshire Boulevard, Los Angeles).—Enuresis may be said to exist when a child has failed to acquire control over the act of urination after his second year. It is unintentional and, as a rule, the unconscious voiding of the large amounts of urine, occurring usually during sleep and in the absence of organic disease of the nervous or genito-urinary systems. Enuresis, more definitely, should apply only to purely functional cases. Since daytime incontinence, found usually during the afternoon nap in about 10 per cent of enuretic children, enuresis and bed wetting have as a rule been considered synonymous. Children who always wet the bed or their clothes have been considered as belonging to the purely functional group. Present-day examinations, especially urologic, have revealed that some type of organic disease exists in about one-half the cases not helped by psychologic or medical treatment. It has been necessary, therefore, to consider that enuresis, as commonly diagnosed, may be (1) a purely functional disturbance (90 to 95 per cent of all cases); and (2) caused by an organic lesion (5 to 10 per cent). The clinical picture may be similar in both types. Campbell has classified enuresis cases as follows:

1. Nocturnal only (80 to 90 per cent).
2. Diurnal only (2 to 4 per cent).
3. Nocturnal and diurnal (8 to 12 per cent).

Any conception of pathologic micturition is necessarily based on a knowledge of a normal physiology of the bladder. The desire to urinate has been found to be dependent more upon intracystic pressure than upon fluid volume. Increased intracystic pressure stimulates the sensory nerve endings in the bladder wall and, by the strength of its contraction, expresses the tonus of the detrusor muscle. The intracystic pressure can be influenced not only by the fluid volume and the voluntary desire to void, but also by irritative, psychic and peripheral reflex stimuli, such as inflammation, running water, or exposure to cold. In eight to ten-year-old children the initial desire to void is felt between 9 to 11 centimeters water pressure, with the fluid volume varying from 80 to 122 cubic centimeters. With normal adults it is 15 to 16 cubic centimeters water pressure, with 140 to 180 cubic centimeters fluid volume. The average physiologic capacity of the bladder is about 100 per cent greater than the volume at which the first desire to void is felt. Since the desire to void depends chiefly upon the intracystic pressure, local irritative or inflammatory, or extracystic reflex stimulations are likely to provoke voiding at a low volume. With voluntary urination the external sphincter is relaxed (or inhibited), probably through cerebral impulses. The functional importance of the pudic nerve has been stressed in this connection. The internal sphincter is opened by a contraction and shortening of the trigon, which pulls open the vesical orifice, and with the simultaneous voluntary contraction of the detrussor, and usually the abdominal muscles as well, the bladder is emptied. Cerebral or voluntary control of urination is normally acquired in childhood. Occasionally the cerebrospinal or peripheral centers remain highly irritable and, with loss of cerebral control by deep sleep or excitement, reflex urination or functional enuresis occurs. Urination is a lower reflex arc function in infants, and is believed to operate through the autonomic extraspinal centers, the bladder emptying with the first stimulus of the desire to void. The age at which voluntary vesical control is acquired varies to some degree. Normally, it may be acquired between the second and third years. In the third year urine should be retained during sleep for eight to nine hours.

Symptomatology may be a varied one. Enuresis usually persists from infancy in most cases. It may suddenly appear months or even years after continence has been established, and last for only a few weeks. There may or may not be identified an immediate antecedent etiologic factor, such as illness, accident or fright. Wetting may occur several times nightly, or a few times a month, or it may be of a relapsing type, with a dry interval of some weeks. Urinary incontinence appearing only at night is called enuresis nocturna. Day wetting is known as enuresis diurna, while in some instances there may be wetting both day and night, or so-called total enuresis. The time of wetting may vary even in the same child, and usually occurs during the early sleeping hours, although it can be delayed until early morning. The child rarely wakes until sometime after the wetting has occurred. Day wetting seldom appears until night wetting is well established. Children who wet the bed at night may commonly suffer with frequency and urgency during the day. Some observers have thought of frequency and urgency as initial symptoms of enuresis. The symptoms are often induced or exaggerated by exposure to cold or undue excitement. Campbell's analysis of symptoms in 532 cases of enuresis revealed the following distribution among the cases: frequency, 532; night wetting, 527; urgency, 361; day wetting, 324; pyuria (hazy urine), 91; dysuria, 87; abdominal pain, 55; intestinal upsets, 29; hematuria (usually due to ulcerated meatus), 19; burning on urination, 12; and loin pain in 9.

Any attempt to search or discuss the element of pathology immediately presents an elusive subject. No true or comprehensive explanation has been made in true enuresis cases. There is no known pathology nor any known factor other than age; it is not a true neurosis, nor is it the result of any known mental or physical defect. It is not adequately explained as a real loss of inhibition. We are really dealing with a child who must urinate at once, because, despite his best intentions and self-control, the trigone through its nerve innervation is pulling the vesical orifice open—or may have already done so—causing the child great urgency and to urinate spontaneously. The fact remains that so many associated factors have been blamed, yet none has consistently been proved. There have been many causative conditions found by urologic study. In this group have been found strictured meati, phimosis, urethral stricture, congenital valves of the posterior urethra, verumontanitis, prostatitis, trigonitis, bladder neck obstructions, neuromuscular bladder disturbances, calculus, tuberculosis, and others.

Urologic examination may be undertaken whenever necessary, especially after the age of four years. The urine is carefully examined for pus and organisms indicating an infection, and for epithelial desquamation and leukocytes indicating inflammation of the urethra and bladder. The bladder is checked for residual urine along with cystometric studies to determine whether the neurologic element is of hypertonic (inflammatory or parasympathetic) or hypotonic (sympathetic imbalance). The usual urologic finding in enuritic girls is urethrotrigonitis, commonly associated with a tight canal, and involving the posterior rim of the urethra and anterior trigon. This resembles the so-called "irritable bladder" in women. In boys the usual picture is a low-grade posterior urethritis and verumontanitis. Some observers have classified these cases in several groups. The first is the atonic form characterized by a low sensitiveness of the mucosa of the urethra and bladder. The second group consists of cases with atonic sphincters, but with increased mucosa sensitiveness. The third group has such cases as show increased bladder irritability, frequent and urgent urination, and mucosal hyperesthesia. The presence of a widely varying degree of therapeusis is proof of an equal varying consideration of etiology, physiology, and pathology. All factors must be carefully weighed, and the case considered from a pediatric, urologic and psychologic point of view.

PROGNOSIS AND TREATMENT

E. W. Beach, M.D. (1127 Eleventh Street, Sacramento).—Because the term enuresis is often loosely employed in medical parlance, it has developed a considerable degree of ambiguity. It seems necessary, therefore, at the outset, before venturing to consider either treatment or prognosis, to contrive an accurate definition of this term in order to form a clear concept as to its denotation. Enuresis per se is neither a disease nor disorder, but constitutes one symptom of a morbid entity. It usually signifies an essential form of incontinence manifested by involuntary micturition with normal structure. Moreover, the urine is always passed in a stream and most often in copious amounts. Enuresis must be clearly differentiated from true, false and paradoxical forms of urinary incontinence. Again, enuresis must not be confused with imperative urgency, nor with so-called bladder atony contingent upon postpartum or postoperative sequelae. As commonly used, the word enuresis is almost synonymous with bed wetting (80 to 85 per cent of cases are nocturnal) and applies to a temporary dysfunction likely incident to the persistence of infantile bladder automatism. Enuresis may be, however, entirely diurnal (2 to 4 per cent of cases) or both night and day in 8 to 12 per cent of cases. Etiologically speaking, most cases fall preponderantly into the functional group (no organic lesion discoverable); but at times enuresis may be predicated upon some definite organic change or lesion in the urogenital tract or anent its subjective innervation.

The Functional Group.—Perhaps 90 to 95 per cent of cases may be segregated under this caption. In this group the enuresis, which is usually nocturnal in type, represents a developmental anachronism and harks back to nursing days when the act of micturition was spontaneous, unconscious, automatic or entirely uncontrolled by the will. In fine, micturition comprises in this epoch a reflex act in response to certain stimuli, and is usually consonant to the degree of bladder distention.

Early training forestalls the persistence of this infantile characteristic—reflex micturition—the latter being replaced by the voluntary mechanism. Discipline soon achieves diurnal results, which gradually become effective during sleep regardless of the depth. Training should be undertaken as early as the seventh, and never delayed beyond the twelfth month. Fluids should be restricted after 6 p. m.; the child should urinate before retiring; he should be aroused about 10 p. m. to be placed on the toilet, and so soon as he awakens in the morning he should be again placed on the toilet. This routine should pay handsome dividends (dry nights) early in the third and certainly by the fourth year.

When enuresis persists beyond the fourth year, a careful and detailed general study of the child should be undertaken by the attending physician. Physical defects, both in the urinary tract and elsewhere, must be sought for and corrected or ruled out. An overly tight urinary meatus is very common—a phimosis with resultant smegma accumulations may be a formidable source of constant irritation. The presence of pinworms as an aggravation must not be overlooked. In certain instances enuresis appears to be somewhat of a family trait, reappearing with almost monotonous regularity in the lineage. Many of these enuretic children are born of discordant parents, and consequently inherit a strong neuropathic taint. These children frequently have a deep sense of physical inferiority, and crave attention or sympathy. They are often irascible, peevish, high-strung, emotionally unstable and yet extraordinarily active. Moreover, because of this shortcoming, these unfortunate children are often kept in a constant state of insurrection by the mother, who makes a battleground of the toilet issue: she alternatingly cajoles, pities, sympathizes, scolds, threatens, intimidates and punishes the little personality, but all to no avail. A spirit of antagonism, helplessness, futility, panic, fear, insubordination, hostility or self-pity, as the case may be, is aroused in the child, all of which conspire to defeat the desired objective.

Having made certain there exists no apparent anatomic or morbid basis for the enuresis, the understanding physician will then attempt (1) to improve the patient's general health and (2) adroitly to manage the psychic complexion of the sufferer. He will at the outset reassure the little patient that he can and will be cured. He will guard his patient against undue emotional turmoil, particularly just before retiring. He will, with the help of the mother, arrange rest periods, supervise play hours, restrict fluid intake after supper, eliminate all condiments from the diet and arouse the child to void at regular intervals during the night. He will advise and wisely counsel the mother and family, so that a new psychic horizon with regard to the child and his habit is fashioned. No discussion of the child's misfortune or "weak kidneys" is permissible in the presence of the child. Inquisitional methods—mechanical gadgets such as strings or clamps about the penis—are absolutely taboo. Hope, optimism and confidence are engendered in the child by the attitude of both the mother and physician working in collaboration with reward for success (as a gold star on banner days), but no mention of failure. A copious dose of suggestion is always beneficial: much reassurance on the part of the physician is helpful, and especially if amplified by some supplementary maneuver such as a sterile water hypodermic often suffices for cure. Patience is required, and often it is mandatory, although extremely difficult to separate the mother and child temporarily in order to achieve the desired result. At times a week or two in the hospital for the child is ample for this purpose; but sometimes it is necessary for the child to become intimately associated with other children in an institution, such as a boarding school, etc. Much ado is made therein as to behavior conformation and his exemplary conduct. Medication.

Many remedies have been advocated, but few are helpful, and none specific nor even certain. The barbiturates, as well as atropin and belladonna, have all been lauded. At times a change in the reaction of the urine is of value. In certain instances endocrin preparations have proven meritorious.

Minor Surgical Procedures.

In many of these discordant little personalities, masturbation is conspicuous. The concomitant posterior urethritis, prostatitis, verumontanitis may require topical applications of silver instillations or the use of sounds. In others meatotomy and circumcision are prerequisites.

Prognosis.

The outlook for the cure of functional enuresis is usually excellent. It rarely persists beyond the age of ten. While the outlook is better when the habit begins before the tenth year, yet in almost every case, even though the habit persists into adult life, cure is certain. Should enuresis prove adamant to the usual medical treatment and psychotherapy for two or three months, it demands a complete urological examination. In this instance enuresis may presage definite organic uropathy. A comprehensive urine study is meritorious with determination as to the absence or presence of residual urine.

The Organic Group.—It is well to remember the enuretic criterion: the patient voids a stream of urine. At times, other forms of incontinence (particularly the type dependent upon congenital or developmental errors, as for instance the ectopic ureter) may be erroneously diagnosed enuresis.

Over half of the therapeutically resistant cases of enuresis show notable organic uropathy. Almost any pathologic condition may exist, viz., tuberculosis, stone, upper urinary tract infection, all grades of cystitis, urethrotrigonitis, seminal vesiculitis, prostatitis, neuromuscular deficiencies, vesical diverticuli, congenital valves in posterior urethra, contracture of vesical neck, polyps in the posterior urethra, urethral strictures, etc. The treatment depends, of course, upon the etiological factor and especially upon its detection. Herein enters the value of accurate urologic diagnosis. The prognosis again depends upon the type and extent of the lesion at hand. Anent neuromuscular disturbance conditions most frequently mentioned are spina bifida occulta and myelodysplasia. Conceivably a relaxed vesical sphincter may result from parasympathetic imbalance. At other times the vesical sphincter may be partially paralyzed or involved in certain neurogenic disorders. It is well to recall, in this connection, that in certain of the acute exanthems the neuromechanism may be implicated secondarily. Fortunately, this type of enuresis is uncommon; it appears suddenly and ends almost as abruptly. The urologic picture in myelo-encephalitis is obviously not that of enuresis.

In conclusion, while it is true that enuresis is usually functional, it behooves the alert physician to guard against pitfalls in the realm of actual uropathy. Therapeutically resistant cases should all be subjected to a comprehensive and painstaking urologic examination, because about 60 per cent in this group show gross morbid deviation. Cure in this group hinges upon the detection of these lesions and appropriate treatment.

Pneumonia.—Pneumonia, fourth in 1937 among the causes of death in the United States, strikes with the greatest frequency in the lower income groups, according to National Health Survey figures recently made public by the United States Public Health Service. The pneumonia case rate among relief families was over twice the rate of that among families in the upper income groups. There was also an excess in the rates among families who were not on relief, but whose incomes were less than $125 per month.

Pneumonia, which disables more than five persons out of every thousand in urban communities during the course of a year, is most prevalent among children and old persons. The annual frequency rate of pneumonia among children under 3 years of age was 18 per 1,000 persons and among persons 65 years and over 11 per 1,000, while the rate among youths and young adults (15 to 44) was only 3 per 1,000.

Men, from birth to old age, are more likely to have pneumonia than are women. For males, the annual frequency rate was found to be 6 per 1,000 persons, while it was only 4.9 for females.

The average duration of nonfatal pneumonia cases was observed to be forty-two days and of fatal cases nineteen days. For all pneumonia cases—fatal and nonfatal—the average period of disability was thirty-nine days. Earlier bulletins from the Health Survey give durations for acute illnesses (disabling for a week or longer) as forty-six days for accidents, twenty-four days for infectious diseases and nineteen days for all respiratory causes. The Survey director points out that a comparison of these figures shows that pneumonia ranks among the most severe acute diseases.

In issuing this report the United States Public Health Service warned that early diagnosis, with prompt and continuous medical care, is recognized as extremely important if the severe course of pneumonia is to be lessened and death prevented. While the services of a doctor are indispensable in the proper treatment of pneumonia, the Federal health authorities also pointed out the important rôle of proficient bedside nursing in the management of this disease and the necessity of hospital care for some cases. Earlier Public Health Service reports have stressed the need for wider and speedier application of serum therapy but have also called attention to the high cost of treatment, whether it includes serum or not. Conclusions from the Health Survey are that those in the upper income groups were given a relatively high degree of care, regardless of the size of the city in which they lived, while those in the lower income groups were less well cared for in the smaller communities than in the larger.

The data gathered by the Survey covered a period (1935–1936) when the death rate of pneumonia was neither unusually high nor low, in comparison with the averages for the years 1921 to 1937. Death rates for pneumonia during this seventeen-year period ranged from 69.1 per 100,000 in 1933 to 108 in 1923. The rate for 1937 was 84.3.

The National Health Survey was conducted by the United States Public Health Service with the aid of financial grants from the Works Progress Administration. The resulting reports are based on a house-to-house canvass of some 800,000 families, including 2,800,000 persons in eighty-three cities and twenty-three rural areas in nineteen states. The Survey was made during the winter (largely from November to March) of 1935–1936.

The total surveyed population was so distributed as to give a sample which was, in general, representative of cities in the United States according to size and region. In large cities (100,000 and over) the population to be canvassed was determined by a random selection of many small districts based on those used in the United States Decennial Census of 1930. In the smaller cities selected for the study, the population was enumerated completely.

CALIFORNIA MEDICAL ASSOCIATION

This department contains official notices, reports of county society proceedings and other information having to do with the State Association and its component county societies. The copy for the department is submitted by the State Association Secretary, to whom communications for this department should be sent. Rosters of State Association officers and committees and of component county societies and affiliated organizations, are printed in the front advertising section on pages 2, 4 and 6.

CALIFORNIA MEDICAL ASSOCIATION†

WILLIAM W. ROBLEE	President
CHARLES A. DUKES	President-Elect
LOWELL S. GOIN	Speaker
KARL L. SCHAUPP	Council Chairman
GEORGE H. KRESS	Secretary-Treasurer

OFFICIAL BUSINESS

ASSOCIATION ACTIVITIES

Council Minutes, Two Hundred and Seventy-Second Meeting, February 25, 1939.

DEPARTMENT OF PUBLIC RELATIONS

1. *Assembly Bill 2172 and Senate Bill 1128 ("Compulsory Health Insurance Bills").*
2. *Southern California Medical Society.*
3. *Cancer Commission Pathologic Conference.*
4. *C. M. A. Postgraduate Committee.*
5. *Postgraduate Conferences on Maternal Care.*
6. *Postgraduate Conferences.*
7. *California Physicians' Service.*

COUNCIL OF THE CALIFORNIA MEDICAL ASSOCIATION

Minutes of the Two Hundred and Seventy-Second (272nd) Meeting of the Council of the California Medical Association *

The meeting was held in Room 209, Sir Francis Drake Hotel, San Francisco, Saturday, February 25, 1939, at 9:30 a. m.

1. **Call to Order.**—The meeting was called to order by Chairman Schaupp. The following councilors were present: Doctors William Roblee, Charles A. Dukes, Howard Morrow, Karl Schaupp, T. Henshaw Kelly, Calvert L. Emmons, A. E. Anderson, Louis A. Packard, O. D. Hamlin, F. N. Scatena, H. A. Rogers, Harry H. Wilson, William H. Kiger, P. K. Gilman, J. B. Harris, G. G. Reinle, George H. Kress. Also present were General Counsel Peart and Mr. Hassard; and (by invitation) John H. Graves and Edward M. Pallette.

Absent: Doctors Carl Howson, A. L. Phillips, C. O. Tanner, and Lowell S. Goin.

2. **Minutes.**—It was moved by C. A. Dukes, seconded by Howard Morrow, that the minutes of the two hundred and seventy-first meeting of the Council be approved. Carried.

3. **Legal Aid.**—After full discussion of a court case of particular interest to medicine, it was moved by William Roblee, seconded by William Kiger, that the Chairman of the Executive Committee, the Chairman of the Legislative Committee, and the Chairman of the Council, with the advice of the General Counsel, be placed in charge of the matter, with full power to act. Carried.

4. **Repayment of Loan.**—The Secretary reported that the California Medical Association, on January 30, 1939, had repaid to the Trustees Of The California Medical Association the sum of $5,000, borrowed from the Crocker National Bank, on a note dated December 13, 1938.

5. **Committee on Public Policy and Legislation.**—Due to the increased work of the Committee on Public Policy and Legislation, and with the approval of the Chairman of the Auditing Committee, it was voted, on motion of William Roblee, seconded by P. K. Gilman, that the Committee on Public Policy and Legislation be allowed, for the time being, the increased requested.

6. **Indemnity Defense Notes.**—It was reported that, in the accounts of the Indemnity Defense Fund there were still outstanding notes to the amount of $330, signed by physicians who had given such notes shortly before the Indemnity Defense Fund was discontinued. The auditors, Ernst & Ernst, had asked that these uncollectible notes be written off through official action.

It was moved by William Roblee, seconded by P. K. Gilman, that uncollectible notes outstanding to the amount of $330, be written off the books and the record closed. Carried.

7. **Publicity.**—The Secretary reported that, in accordance with the mail vote of the Executive Committee, authorized by Chairman Kelly, regarding participation of the California Medical Association in the publicity regarding the opening of the Golden Gate International Exposition, a majority of the Executive Committee having approved the expenditure, contracts had been entered into with the Examiner, Chronicle, Call-Bulletin, San Francisco News, and the Post-Enquirer of Oakland.

Doctor Kress stated that, after the appearance of the advertisements, coöperation for like publicity had been solicited by the Sacramento Bee and the Tribune of Oakland.

It was moved by Charles Dukes, seconded by Louis Packard, that the Oakland Tribune and the Sacramento Bee each be granted a complimentary announcement on the basis of the amount granted to the other Oakland newspaper. Carried. Doctors Roblee and Morrow voted in the negative.

8. **Animal Experimentation.**—Discussion was had of the present provision governing pounds. Doctor Harris and Doctor Gilman outlined the necessity for better regulation, stating that a bill had been prepared by the California Society for the Promotion of Medical Research.

It was moved by William Roblee, seconded by William Kiger, that the Special Committee on Animal Experimentation, in coöperation with the Committee on Public Policy and Legislation, proceed with the enactment of legislation to provide for better regulation of pounds. Carried.

9. **Hospital Legislation.**—Doctor Packard reported that the proposed hospital bill had been introduced in the Legislature, and it was believed that only minor amendments would be necessary. Also, that the future action regarding the legislation should be placed in the hands of the Committee on Public Policy and Legislation.

10. **Nurses' Legislation.**—It was pointed out that, until the Nurses' Bill contained definite minimum standards of

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† For complete roster of officers, see advertising pages 2, 4, and 6.

* The minutes of the two hundred and seventy-first (271st) meeting of the Council of the California Medical Association were printed in the February, 1939, issue of CALIFORNIA AND WESTERN MEDICINE, on page 136.

training, consideration by the California Medical Association and its Legislative Committee was inadvisable.

11. **Free Choice of Physicians.**—An amendment to Section 402.5 of the Penal Code, relating to the free choice of physicians, was discussed, and was referred to the Committee on Public Policy and Legislation.

12. **Pacific Coast Medical Executives Conference.**—The Secretary reported that, at the last Conference of the Executive Officers from the State Association of the Pacific Coast, a permanent organization had been established through the organization of the Pacific Coast Medical Executives Conference, and that an agreement had been made that each state medical association would contribute the sum of $10 for postage, stationery, etc., to cover routine expenses between the annual meetings.

It was moved by Charles Dukes, seconded by Louis Packard, that the California Medical Association contribute $10 to the Pacific Coast Medical Executives Conference. Carried.

13. **California Physicians' Service.**—A resolution adopted by the Council of the Alameda County Medical Association at its recent meeting was presented. Since the resolution requested action which was not within the jurisdiction of the Council of the California Medical Association, and which was properly the business of the Board of Trustees of the California Physicians' Service, the entire matter was referred to the California Physicians' Service.

The Secretary was instructed to inform the Alameda County Medical Association of the action taken by the Council.

14. **Legal Services.**—Statement of legal services rendered to the California Medical Association in connection with the medical service plans of the California Medical Association, pursuant with instructions of the Council at its meeting, held November 12, 1938, up to the date of the caucus meeting of Trustees of the California Physicians' Service held on January 28, 1939, and in the amount of $2,626.07 was presented by General Counsel Hartley Peart.

It was moved by Charles Dukes, seconded by Axcel Anderson, that the bill of the legal counsel to the California Medical Association in the amount of $2,626.07 be approved. Carried.

15. **Foreign Graduates.**—It was moved by William Roblee, seconded by Calvert Emmons, that Assembly Bill 449, relating to citizenship of physicians, be referred to the Legislative Committee, with the approval of the Council, that the recommendation do pass. Carried.

16. **Retired Members.**—The Secretary reported that requests for retired membership had been received from the governing bodies of respective county societies for members who had retired from active practice, and who complied in other respects with the provisions of the by-laws governing retired membership.

It was moved by Charles Dukes, seconded by Howard Morrow, that retired membership in the California Medical Association be granted to John C. Neilsen, San Diego County; Angeline Martine, San Diego County; E. W. Bathurst, Siskiyou County; Timothy Lyman, Sacramento County; James Hunt O'Connor, San Francisco County; H. A. Brown, Alameda County; and J. J. Tully, San Joaquin County. Carried.

17. **Kern County.**—The General Counsel reported on activities of a member of a component county society relative to legal action taken following expulsion.

It was pointed out that expense up to the sum of $500 had been authorized, but no demands had been made upon the allocation to date.

18. **Stenographic Legal Expense.**—The Secretary reported that, in compilation of the Auditing Committee for a Budget of Expenses, which would be approved at the next annual session by the House of Delegates, the item of stenographic legal expense had been eliminated, and asked for instructions as to the payment of such expense in the interim of January, 1939 to May, 1939.

It was moved by T. Henshaw Kelly, seconded by Harry Wilson, that the payment of $75 monthly to the Legal Counsel for legal stenographic expense be continued until May, 1939. Carried.

19. **Adjournment.**—The Council then adjourned, to permit its members to take part in the proceedings of the Third Annual Joint Conference of State Association officers and Committeemen with the Secretaries of the Component County Medical Societies.

George H. Kress, Secretary.

Attest:
Karl L. Schaupp, *Chairman.*

C. M. A. DEPARTMENT OF PUBLIC RELATIONS†*

ASSEMBLY BILL 2172 AND SENATE BILL 1128: ("COMPULSORY HEALTH INSURANCE BILLS")

The Public League of California recently sent out an interesting digest of the compulsory health bills (Assembly Bill 2172 and its companion measure, Senate Bill 1128). We have inserted subheads in italics to emphasize the text. The analysis is worthy of careful consideration by every Doctor of Medicine in California.

* * *

Assembly Bill 2172 and its companion, Senate Bill 1128, are said to be "Administration" Bills. According to the newspapers, these bills are sponsored by and supported by Labor's Non-Partisan League and "a number of liberal organizations."

Use of Existing California "Unemployment Fund."

They establish a system of health insurance within the system of unemployment reserves. There is now $130,000,000 reserve in the Unemployment Fund, contributed by employers and workers as a sacred trust against unemployment. Does this new scheme plan to tap this unemployment reserve fund and use it for health insurance?

Employees Included.

The bills regiment every worker earning up to $3,000 per year. Employing units which at any time during the year have any individual in employment come under the plan. See Section 155.

Deduction from Wages of Employees; Tax on Employers; Levies on State Funds.

In addition to the amounts already being deducted from the worker's pay check for Federal and State reserves, there will be deducted from ½ per cent to 1½ per cent from their wages. The employer will have to contribute up to 2 per cent, which is added to his already heavy taxes. Beginning with July, 1941, the State must contribute as high as 1 per cent. This will add a large sum to our taxes. In 1941 the total payroll contributions for Federal Security plans, State unemployment reserves, and health insurance will reach 9 per cent.

Regimentation of Wage-Earners, Physicians, Surgeons, Dentists, Nurses, and Hospitals.

Not only are all workers earning up to $3,000 per year regimented, but physicians and surgeons, dentists, nurses, and hospitals will be regimented. Every worker must select a physician and surgeon to supervise his health at all times.

If he fails to make such selection, one is arbitrarily assigned to him.

No Definite Remuneration Provided for Doctors of Medicine.

There are no provisions for the amount of remuneration the physician is to receive, and Section 304 even gives the State the authority to fix the number of patients he may serve. An influential doctor might be assigned five thousand patients.

Specialists (Such as Are Appointed) to Work in "Diagnostic Health Centers."

X-ray, laboratory services, and specialists and consultants' services will be rendered in public centers or let under contract at rates fixed by the State.

"Chain Drug Stores" May Handle the Entire Drug Business Involved.

Drugs and medicines may be purchased from any pharmacy which has agreed to sell them at prices fixed by the governing authority. It would be possible for a large chain to contract with the State at prices that would force the thousands of independent pharmacies out of business.

A "Governing Authority" Would Have Supreme Control.

The governing authority has full power to fix remuneration for nursing, hospitalization, dentistry, etc. See Section 306.

No Guarantees as to Amount of Service to Be Rendered.

The worker is given no guarantee as to what length of service he is to receive and is at the mercy of the governing authority. See Section 235.

A "Bureau of Medical Service" to Be Established as an Adjunct to the Unemployment Phases.

The scheme sets up a new State Bureau, known as the Bureau of Medical Service, and places full administration of the health of all workers in the State earning up to $3,000 per year and all doctors serving them in the hands of a medical director.

Kind of "Medical Advisory Board" to "Advise" the Medical Director.

Although medical men are presumed to be best fitted for advising on health administration, and medical societies have been studying this problem for many years, they *are not* represented on the Advisory Council which assists the Medical Director. This Council is made up of three representatives of labor and two representatives of employers. When this Council acts in an advisory capacity to the Bureau of Medical Service, two physicians are added, but no physicians are on the Council when it assists the director in administering this vast scheme.

A New California Bureaucracy, and for What?

Careful reading of the bills will bring out many more points which are of serious concern to all citizens of the State.

These bills would set up another new bureaucracy, add additional tax burdens to workers, employers, and all citizens in general and embark California on an untried scheme of social insurance. It is impossible to estimate the hundreds of millions of dollars that such a scheme will collect from workers, employers, and general taxpayers.

Proposed Laws Are Ill-Advised and Unnecessary.

These bills are unnecessary because the physicians of the State have already voluntarily established a plan to provide hospital and medical care on a proper actuarial basis at reasonable rates.

SOUTHERN CALIFORNIA MEDICAL SOCIETY

In the March issue, on page 227, was given the program of papers presented at the one hundredth semi-annual meeting of the Southern California Medical Association—which until the Medical Society of the State of California was reorganized under American Medical Association sponsorship in 1901, was almost equal in influence in the southern portion of California.

On Wednesday evening, March 15, at the California Club, a formal dinner was sponsored, in commemoration of the event.

The program follows:

Address of Welcome.—John C. Ruddock, M.D., President.

Edward M. Pallette, M.D., Toastmaster

Guest Speakers

The Campaign Against Rheumatism.—Philip S. Hench, M.D., Associate Professor of Medicine, Mayo Foundation, University of Minnesota, Rochester, Minnesota.

Then and Now.—William W. Roblee, M.D., President of the California Medical Association, Riverside.

Postgraduate Training.—William J. Kerr, M.D., Professor of Medicine, University of California, President of American College of Physicians, President of American Heart Association, San Francisco.

Remarks.—Donald C. Balfour, M.D., Professor of Surgery, Mayo Foundation, University of Minnesota, Past President of American College of Surgeons, Regent of American College of Surgeons, Rochester, Minnesota.

Medical Problems of the Day.—Rock Sleyster, M. D., Medical Director of Milwaukee Sanitarium, President-Elect of American Medical Association, Wauwatosa, Wisconsin.

Informal addresses were also made by Howard Morrow, M.D., President of the California State Board of Public Health, San Francisco, and by George H. Kress, M.D., Secretary of the California Medical Association, San Francisco.

* * *

The officers of the Southern California Medical Association for the year 1939 are:

John C. Ruddock, Los Angeles, president; P. A. Gray, Santa Barbara, first vice-president; Milo K. Tedstrom, Santa Ana, second vice-president; John B. Doyle, Los Angeles, secretary-treasurer.

Councilors—Robert W. Langley, Los Angeles; Merrill W. Hollingsworth, Santa Ana; William H. Barrow, San Diego; John C. Ruddock, ex officio; John B. Doyle, ex officio.

Board of Governors—F. M. Pottenger, Los Angeles; Egerton L. Crispin, Los Angeles; Joseph K. Swindt, Pomona; Charles T. Sturgeon, Los Angeles; Paul E. Simonds, Riverside; Raymond G. Taylor, Los Angeles; Fred B. Clarke, Long Beach; Carl R. Howson, Los Angeles; Bon O. Adams, Riverside; H. Douglas Eaton, Los Angeles; Frank R. Nuzum, Santa Barbara.

CANCER COMMISSION PATHOLOGIC CONFERENCE

The usual semi-annual Microscopic Conference of the Cancer Commission of the California Medical Association will be held at the Hotel Del Monte on Sunday, April 30, 1939, at 9:30 a. m. This meeting will be conducted in the same manner as in the past; case histories being presented and slides passed out for diagnosis by each attendant. A very interesting group of cases has been assembled, and it will be necessary for each attendant to bring his own microscope.

The meeting will consist of morning and afternoon sessions, and will be conducted by the following committee: Dr. Paul Michael (chairman), Dr. Jesse Carr, and Dr. Alvin Cox.

Please make reservations with the chairman of the committee at 434 Thirtieth Avenue, Oakland; or with Dr. Otto H. Pflueger, Secretary of the Cancer Commission, 384 Post Street, San Francisco.

C. M. A. POSTGRADUATE COMMITTEE

Clinical Conferences in Prospect.—The California Medical Association Committee on Postgraduate Activities has received reports from, and is carrying on correspondence relative to prospective postgraduate conferences with the County Societies listed below. At the time of this writing, it is not possible to give places and dates of meetings, or names of topics and of guest speakers. Mention is made of the plans under way, in the hope that other component county societies will also take up a consideration of postgraduate conferences. The items of transportation expense, and of amount of time demanded of guest speakers are important, since there is a very definite limit in these matters.

County societies that have taken up active consideration of postgraduate work include the following:

Fresno, Humboldt, Los Angeles (Monrovia, Long Beach), Monterey, Orange, Placer, Riverside, San Diego, San Joaquin (has a definite postgraduate plan of its own), San Luis Obispo, San Mateo, Santa Barbara (with Kern, Ventura and San Luis Obispo counties), Siskiyou, Sonoma, Stanislaus, Yuba-Sutter.

POSTGRADUATE CONFERENCES ON MATERNAL CARE

Tentative Schedule of Harold W. Teel, M. D., Assistant Professor of Obstetrics, Harvard Medical School, and Attending Physician to Boston Lying-In Hospital.

Courses to Be Under the Joint Sponsorship of the Committee on Postgraduate Activities of the California Medical Association and the Bureau of Child Hygiene of the California Department of Public Health.

The California Medical Association Committe on Postgraduate Activities calls the attention of component county medical societies to a series of clinical conferences on maternal care to be given in the cities listed in the tentative schedule which appears below.

Professor Teel is in the State on a special teaching assignment at the University of California, where he gives lectures on Tuesdays and Wednesdays of each week.

On other days, in association with representatives of the California State Board of Public Health, he will be in position to hold clinical conferences in the places scheduled. The dates and places are tentative, but are submitted as a preliminary notice of the plans now being formulated.

Professor Teel is well known as a teacher, and in each place to be visited will be glad to talk on those phases of obstetric and allied work in which the physicians who attend may have special interest. In addition, his professional services will be available as a consultant (no fee being charged) with any physicians who may wish to confer with him on problem cases.

Through the local representatives of the Bureau of Child Hygiene of the California Department of Public Health, efforts will be made, through consultation with county society officers and members interested, best hours and places for the conferences. These naturally must fit in somewhat with the transportation facilities of the guest speaker. If use of place of meeting must be paid for, this expense should be borne locally.

For additional information, write to California Medical Association Postgraduate Committee, 450 Sutter, San Francisco. Suggestions are welcomed.

POSTGRADUATE CONFERENCES

A postgraduate conference of the third councilor district (Santa Barbara, Kern, San Luis Obispo, and Ventura counties) was held on Saturday and Sunday, March 18 and 19, at the Mar Monte Hotel in Santa Barbara.

The scientific sessions convened in the Bissell Auditorium and Cottage Hospital.

*California Maternal Care Lectures—Tentative Schedule**

Conference Number	Trip No.	Date 1939	County	Town	
1	I	April 11	Yolo	Woodland	....
2		April 12	Fresno	Fresno	April 13—a. m.
3		April 13	Kern	Bakersfield	April 14—a. m.
4		April 14	Kern	Taft	April 15—a. m.
5		April 17	Kings	Hanford	Date not decided
6		April 18	Contra Costa	Martinez	Date not decided
7	II	April 19	San Joaquin	Stockton	April 20—a. m.
8		April 20	Tulare	Visalia	April 21—a. m.
9		April 21	Madera	Madera	April 22—a. m.
10		April 24	Stanislaus	Modesto	Date not decided
11		April 25	Santa Clara	San Jose	Date not decided
12	III	April 26	Marin	San Rafael	April 27—a. m.
13		April 27	Sonoma	Santa Rosa	April 28—a. m.
14		April 28	Humboldt	Eureka	April 29—a. m.
15		April 29	Mendocino	Ukiah	Date not decided
16		May 1	Solano	Vallejo	Date not decided
17		May 2	Napa	Napa	Date not decided
18	IV	May 3	Butte	Chico	May 4—a. m.
19		May 4	Yuba	Marysville	May 5—a. m.
20		May 5	Sacramento	Sacramento	May 6—a. m.

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* As stated in text description, consultations may also be arranged.

BOARD OF MEDICAL EXAMINERS OF THE STATE OF CALIFORNIA

Top row, left to right: Frederick W. Didier, M.D., Wheatland; John MacLean, M.D., Los Angeles; Percival Dolman, M.D., San Francisco; Charles E. Schoff, M.D., Sacramento; Lionel Brown, Esq., Deputy Attorney General, San Francisco; Fred R. DeLappe, M.D., Modesto, and Ralph Sollars, Court Reporter.

Seated, left to right: George Thomason, M.D., Los Angeles; Clark L. Abbott, M.D., Vice-President, Oakland; William R. Molony, M.D., President, Los Angeles; Charles B. Pinkham, M.D., Secretary-Treasurer, San Francisco; and William H. Geistweit, Jr., M.D., San Diego.

The Woman's Auxiliary to the Santa Barbara County Medical Society sponsored a no-hostess luncheon and drive on Saturday.

The program of the Clinical Conference follows:

Saturday, March 18, 1939

9:00 a. m.

Clinico-Pathological Conference.—Dr. P. A. Gray, Jr., and Dr. Clark E. Brown.

9:45 a. m.

Nephritis.—Dr. T. Addis.

10:45 a. m.

Head Injuries.—Dr. D. G. Dickerson.

11:30 a. m.

Drugs and Therapeutics: Sterol Drugs, Vitamins, Sex Hormones, Cardiac Glucosides.—Dr. Chauncey Leake.

12:30 p. m.

Luncheon in the Cottage Hospital.

2:00 p. m.

Blood Dyscrasias.—Dr. Madeleine A. Fallon.

3:00 p. m.

Autonomic Drugs.—Dr. Chauncey Leake.

4:00 p. m.

Injuries of the Hand.—Dr. Nelson Howard.

2 to 5 p. m.

Ear, Nose, and Throat Round Table.—Dr. McKenzie Brown.

* * *

On Saturday evening a dinner was given at the Montecito Country Club, at which the speaker was Dr. Leo Eloesser, his topic being "The War in Spain."

Dinner was followed by dancing, after ten o'clock.

On Sunday, March 19, the program continued:

10:00 a. m.

Abdominal Hemorrhage.—Dr. Charles Phillips.

11:00 a. m.

Tumors of the Breast.—Dr. Nelson Howard.

12:00 noon

Menstrual Disorders.

* * *

The attendance was excellent, and the members who were present, some ninety or more, adopted plans for the next conference of the series.

CALIFORNIA PHYSICIANS' SERVICE*

Informative Bulletins

I. Bulletin of March 6, 1939

California Physicians' Service, a plan to provide the benefits of medical, hospital and surgical care to wage-earners at the lowest possible cost, was launched today when more than 10,000 licensed doctors of medicine in the state received application blanks for membership.

California Physicians' Service, a nonprofit corporation, soon will offer the public a group payment plan whereby employed or other groups of persons, by making small monthly payments, can have medical, surgical and hospital bills paid. It is the outgrowth of ten years of study by the California Medical Association.

State headquarters have been opened at 220 Montgomery Street, San Francisco. District headquarters throughout the state will be opened as rapidly as organization can be completed.

Similar plans, successfully operated in the United States during recent years, were studied by a committee which reported the California Physicians' Service plan as embodying the best provisions of each.

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* Address: 220 Montgomery Street, San Francisco. Telephone: Exbrook 3212.

So that residents of California becoming beneficiary members may receive professional services by the physicians of their choice, application blanks were delivered to all licensed doctors of medicine in the state. Arrangements are progressing with existing nonprofit hospital associations, which have offered coöperation, to permit personal choice of hospitals by patients.

The House of Delegates of the California Medical Association, by overwhelming vote, caused formation of and authorized advance of money to start the movement. California Physicians' Service, however, is not a part of the California Medical Association. All doctors who become professional members of the Service will elect the administrative members.

The first board of trustees and officers are: Dr. Ray Lyman Wilbur, President of Stanford University, who is president; Dr. C. Kelly Canelo, San Jose, vice-president; Dr. Lowell S. Goin, Los Angeles, vice-president; Dr. Alson R. Kilgore, San Francisco, secretary-treasurer; Dr. T. Henshaw Kelly, San Francisco, assistant secretary-treasurer; Dr. Samuel Ayres, Jr., Los Angeles, and Dr. W. Earl Mitchell, Berkeley; Dr. Morton R. Gibbons, Sr., San Francisco, medical director. Allen W. Widenham is general manager.

* * *

II. Bulletin of March 13, 1939

Applications from licensed doctors of medicine in California for membership in the California Physicians' Service are numbering better than five hundred per day. This has advanced the time at which this new group prepayment medical, surgical and hospital service can be offered the public, it was announced today by . . .

The Service, which permits wage-earning groups voluntarily to pay small sums monthly, in return for which the members receive care by the doctors and hospitals of their own choice when needed, was launched officially only a week ago. Trustees of the Service today expressed gratification at the prompt support by doctors.

"The first requirement of this plan is a state-wide organization of the doctors and hospitals invited to professional membership," said . . . "The prompt response of the doctors, which is in excess of our anticipations, will permit completion of our organization much sooner than expected. In consequence, we shall be able to proceed to the next step—the enrollment of beneficiary, or patient, members very shortly." . . . revealed today that the California Physicians' Service is based on the same plan that has been in successful operation in King County, Washington, and elsewhere, for several years.

"Much of the experimental work in voluntary group medical, surgical and hospital care has been done by the King County service, with headquarters in Seattle, and in other Northwest cities," he said. "As a result, we sent a delegation North to study their several plans, and we are able to offer a service to Californians, with the customary trial-and-error methods eliminated. We have included the best provisions of all plans studied in our service."

Both patients and physicians in King County are highly pleased with results, the delegation learned.

Present headquarters for the California Physicians' Service are at 220 Montgomery Street, San Francisco, but additional offices will be rapidly established throughout the state.

* * *

III. Bulletin of March 20, 1939

Membership by licensed doctors of medicine in the California Physicians' Service now represents every section of California, Dr. Ray Lyman Wilbur, president of the new monthly prepayment plan for medical, surgical and hospital care, said today.

Because of the immediate state-wide response to the invitations to licensed doctors of medicine to become professional members, it will be possible to make up the first list of professional members who will provide medical and surgical services. The list will be sent to the printer on April 1, Doctor Wilbur said.

Many letters from doctors seeking additional details of the California Physicians' Service plan have been received. Doctor Wilbur today urged all doctors desiring additional information on specific points to communicate with state headquarters of the Service at 220 Montgomery Street, San Francisco.

The plan represents ten years of study of existing plans in this and other countries by leaders in the medical profession of California. The coverage to be offered will include the good points of the plans studied. Professional membership is open to all licensed doctors of medicine in good standing in California. California Physicians' Service is an independent, nonprofit corporation, not connected with any other association.

Individual beneficiary, or patient, members will make nominal monthly payments to their group representative, who in turn will remit in a lump sum to the California Physicians' Service. When medical, surgical or hospital care becomes necessary, the beneficiary member will select the doctor and hospital of his or her own choice from among the professional members and hospitals covered by the Service.

* * *

IV. Bulletin of March 25, 1939

Election of leaders in both medical and nonmedical fields in California as administrative members of the California Physicians' Service, the new monthly prepayment plan for low-cost group medical, surgical and hospital service, was announced today by President Ray Lyman Wilbur.

Those added to the board of present administrative members in Los Angeles included: Glenn Myers, president of the California Hospital Association; Monsignor Thomas J. O'Dwyer, vice-president of the Western Conference, Catholic Hospital Association Southern Council; E. Manchester Boddy, publisher of the Los Angeles *Daily and Evening News*; Carl Erickson, vice-president of the Zenith Oil Company; John Anson Ford, Los Angeles County supervisor; and Reverend Ernest Caldecott, pastor of the First Unitarian Church of Los Angeles.

Elected from San Francisco and Northern California were: Daniel E. Koshland, member of Executive Committee, San Francisco Community Chest; Dr. Tully C. Knoles, president of the College of the Pacific; and Ernest Sloman, dean of the College of Physicians and Surgeons' Dental School.

"Additional nonmedical as well as medical administrative members will be appointed," Doctor Wilbur said. "This procedure will give California Physicians' Service the best obtainable in nonmedical as well as in medical advice and will insure full representation of the public, to which this service is dedicated. It will make certain a most complete and satisfactory service."

Professional membership in California Physicians' Service has been acquired by more than half the licensed doctors of medicine in actual private practice in California to date, Doctor Wilbur said. Invitations to membership were issued on March 6, and acceptances continue to arrive at state headquarters, 220 Montgomery Street, San Francisco, at a rate of more than one hundred a day.

* * *

V. Bulletin of March 29, 1939

Support by every citizen of California for the California Physicians' Service, the new monthly prepayment plan for group medical, surgical and hospital care, was urged today by Monsignor Thomas J. O'Dwyer, Vice-President of the Western Conference, Catholic Hospital Association, Southern Council, who has just been elected an administrative member of the Service.

"The doctors of California deserve the highest commendation for being the first state group in the United States to initiate a sound plan of voluntary health care," Monsignor O'Dwyer said. "There is nation-wide interest in their plan. California Physicians' Service deserves the support of every citizen of the state. I am happy to be able to participate in an advisory capacity in this movement."

Daniel E. Koshland, for many years a member of the Executive Committee of the San Francisco Community Chest, and a member of the Advisory Committee of the Insurance Association of Approved Hospitals, who is another new administrative member of California Physicians' Service, said:

"I am convinced the group hospital plan is working. The addition of medical and surgical care completes the plan. Steps have been taken quietly, steadily, and soundly. I am glad to be one of the group of business men to assist California Physicians' Service. I believe participation by business and hospital representatives will be of great aid to the doctors in making this fine service successful."

* * *

News Items: C. P. S.

Applications for professional membership have been received to date from 3,731 physicians. It is estimated conservatively that this is well over 50 per cent of the total number of physicians available for private practice. (Of the 10,000 licensed, the number who are retired and in full-time teaching, public health, state hospital and other institutional positions, internes and residents in general hospitals, etc., is very large.) From 100 to 200 applications are coming in daily. That California Physicians' Service has the support of the profession is abundantly apparent.

* * *

The election, completed on Friday, added nine new administrative members: Mr. E. Manchester Boddy, Publisher of the Los Angeles *Daily and Evening News*; Rev. Ernest Caldecott, Pastor, First Unitarian Church of Los Angeles; Mr. Carl R. Erickson, Vice-President of Zenith Oil Company, Los Angeles; Mr. John Anson Ford, member of Board of Supervisors of Los Angeles County; Dr. Tully C. Knoles, President of the College of the Pacific, Stockton; Mr. Daniel Koshland, member of the Executive Committee, San Francisco Community Chest; Glenn Myers, M.D., President of the California Hospital Association; Monsignor Thomas J. O'Dwyer, Vice-President of the Western Conference, Catholic Hospital Association, Southern Council; Ernest Sloman, D.D.S., Superintendent of the College of Physicians and Surgeons' Dental School.

It is with gratification and sincere appreciation that we welcome these public-spirited men to the administrative group.

* * *

The amendment to the by-laws, increasing the trustees from seven to nine, was passed and it is expected that the two vacancies thus created will be filled as soon as the necessary legal forms have been signed.

* * *

Dr. E. Vincent Askey has accepted appointment as assistant medical director, with headquarters at Los Angeles.

* * *

Los Angeles offices will be opened in the Pershing Square Building, 448 South Hill Street, on April 1.

* * *

District organization will be undertaken by the trustees at the next meeting, scheduled for this week-end in Los Angeles. In the appointment of deputy medical directors, every effort, by previous conferences and consultations, will be made to secure the services of men whose appointments will be satisfactory to the professional members of the respective districts.

Substantial agreement on a uniform hospitalization contract has been reached by the three nonprofit hospital associations and we expect to announce shortly the signing of definitive contracts for hospitalization of California Physicians' Service beneficiaries. As soon as this is done we shall be ready to negotiate contracts with beneficiary groups.

* * *

For purposes of negotiating contracts with groups of beneficiary members (which we hope to do in April) it is necessary that we have a printed list of professional members. The task of checking, indexing and arranging alphabetically, and by counties, 4,000 or 5,000 physicians' names is a large one. To have such a list ready for use in April we shall have to send copy to the printer as soon after April 1 as it can be prepared. A courtesy notice by postcard was, therefore, mailed to all licensed doctors of medicine approximately ten days ago, announcing that such a list of professional members would be prepared as of April 1. Printing a list of this size is expensive, as you can well appreciate.

* * *

In the establishment of rates, etc., your trustees have kept constantly in mind that the California Physicians' Service plan is one which must be kept financially solvent. We cannot fall back on the taxpayers of the state to make up deficits.

The following policies have been developed so far:

Rates.—Standard average monthly dues of $2.50 per member for groups with average income of under $3,000 annually, for full coverage (without "deductible clause"). In so far as possible, in negotiating contracts with groups, an attempt will be made to adjust a sliding scale, according to income, to make the average $2.50.

In addition, various other contracts will be offered, *e. g.*, contracts with "deductible" clauses covering from $1 to $10 or more of the cost of initial service, at average rates ranging from $2.25 per month down to less than $2 per month.

As soon as group service has been well started we expect to offer coverage for the *families of members* and also for *individuals,* the latter at somewhat higher rates (due to the greater expense of administration) and after examination. In the meantime, hospitalization contracts for families will be available at once through the hospital associations.

* * *

Fee Schedule.—For our purposes the fee schedule is to be a measure of the *relative* compensation to be paid for various procedures in practice. It is in no sense a guarantee of rates of compensation. These will be determined on the "unit basis." The committee in charge of development of the schedule has been holding conferences with physicians in the various specialties involved and is finding it no simple matter to arrive at a schedule satisfactory to all. However, the trustees expect to announce shortly a schedule with which operations can be started. This schedule will be subject always to adjustment as experience dictates. It should be borne in mind that your trustees are handicapped by the usual human frailties and limitations. Not being prophets, they do not expect to foresee every contingency that may arise in the operations of a plan of the magnitude of California Physicians' Service. They expect that fee schedules, contracts, rules and organizational details will require modification in the light of experience. Attention may be again directed to the fact that the California Physicians' Service plan is not based upon legislation. It will be subject to the control of its members through the trustees and advisory committees representing the beneficiary members served and others interested. Changes can be made as they appear desirable. And if the trustees do not change unsatisfactory matters, the members can change the trustees.

COUNTY SOCIETIES

PLACER COUNTY

The Placer County Medical Society held its March meeting at the Freeman Hotel in Auburn on March 4, with a dinner meeting commencing at 6:30 p. m. In the absence of President Miller and Vice-President Empey, Past President Robert H. Eveleth presided.

There were present the following members and visitors: *Members:* Doctors Barnes, Dunievitz, Eveleth, Foster, Hirsch, Kindopp, Lewis, Lundegaard, Padgett, Peers, Rood, and Russell. *Visitors:* Dr. F. N. Scatena (Councilor for the Eighth District), Dr. F. F. Gundrum, and Dr. Paul Guttman, all of Sacramento; Dr. Robert Stewart Peers of Oakland, and Dr. W. J. Perry of the C. C. C., Camp Bradley, Auburn.

All correspondence since the previous meeting was read, among which were the following:

Correspondence from Association Secretary Kress relative to Postgraduate Clinical Conferences. Dr. F. F. Gundrum, a member of the Committee on Postgraduate activity being present, discussed the subject of *Postgraduate Courses for Placer County Members.* It was agreed that the members of the Placer County Medical Society would coöperate and would attend such conferences when held in neighboring counties.

Letter from Dr. John H. Napier, Jr., District Superintendent and Director of the Placer Union High School and the Placer Junior College, asking that the Placer County Medical Society make a study of the Placer Union High School and Junior College with the view to making recommendation for a thorough-going health department in these institutions. It was the sense of the members that President Miller and Secretary Peers consult with Doctor Napier and report back to the Society.

Secretary Peers then took up with the Society the California Physicians' Service. He reported on the meeting of February 25 of the county secretaries with the Council and officers of the California Medical Association and the members of the various committees, at which time a number of addresses on the California Physicians' Service were given. The Secretary stressed the importance of having as many members as possible make application for professional membership. Doctor Scatena, spoke at length on the same subject, urging that each member of the Society take out membership in the California Physicians' Service, and stated that it is particularly important that succh membership be acquired immediately so that it may become known that the medical profession has a going organization, ready to furnish medical care on an insurance basis. There was general discussion, and Doctor Scatena answered many questions by the members. It was moved by Doctor Hirsch, seconded by Doctor Dunievitz, that the Placer County Medical Society endorse the California Physicians' Service and that the Secretary be instructed to write every member, urging prompt registration. Unanimously carried.

The application for membership in the Placer County Medical Society of Dr. Frederick Harry Benteen of Grass Valley was read for the first time, but as Doctor Benteen has not practiced the required six months in the district, no action was taken.

Following this, Doctor Eveleth introduced Dr. Paul Guttman of Sacramento, who addressed the Society on *Newer Methods of Typing in Pneumonia.* The address was illustrated by lantern slides. Doctor Guttman discussed the various organisms involved in the production of pneumonias, giving the approximate percentages of the different bacteria, and described the various types of pneumococci which have been isolated, giving the approximate percentages of the different varieties in the order of their importance. Also the various methods of typing, particularly the Neufeld method, which is now used mainly to the exclusion of other methods, and spoke also of sera used in the treatment of various types of pneumococcus pneumonia.

Dr. F. F. Gundrum of Sacramento, being called upon, spoke on *The Newer Methods of Treatment in Pneumonia.* Doctor Gundrum reviewed the various methods of treatment which had their vogue the past few decades, showing that over a period of time the death rate was approximately the same irrespective of the type of treatment. He then discussed the use of sera, the dosage and methods of administration. He also commented on the recent use of sulfanilamid and also spoke briefly on the more recent member of the sulfanilamid group, sulfapyridin.

The discussion was opened by Dr. Robert Stewart Peers of Oakland, who gave a history and showed x-ray films of a cast of pneumonia in a middle-aged Italian woman in whom the diagnosis was made within twenty-four hours of commencement of the attack. Specific serum was used with rather spectacular results. Doctor Peers also spoke on the different types of pneumococci. Following this there was very general discussion in which all members present took part.

Robert A. Peers, *Secretary.*

⁂

SAN JOAQUIN COUNTY

The regular meeting of the San Joaquin County Medical Society was held in the Medico-Dental clubrooms, Stockton, March 2, at 8:30 p. m. It was preceded by the customary supper meeting, held at the Hotel Wolf, at which thirty-one members and guests were present. The paper of the evening was presented by Mr. Lee Hixson, Pharmacist, who talked on *Pharmaceutical Problems That Are Common Both to the Physician and Pharmacist.*

The regular meeting was called to order by President Neill P. Johnson at 8:30 p. m. A report on the application of Dr. J. J. Tully for retired membership was made by the Secretary, with a statement that it had been referred to the California Medical Association after a telephone vote of the Board of Directors. Dr. Dewey Powell then reported on the progress of the California Physicians' Service. Questions were answered by both Doctor Powell and Dr. Karl Schaupp, who was present as a speaker. Doctor Broaddus then presented certificates to newly elected members of the Medical Academy of Graduate Study.

A fee schedule of the Metropolitan Life Insurance Company for medical services to their representatives was presented by the Secretary. This schedule received a general approval.

The speaker of the evening was Dr. Karl Schaupp of San Francisco. Doctor Schaupp talked on *Analgesia in Labor and on the Cause and Treatment of Leukorrhea.* Both papers were short and of real practical value.

The members of the Society were urged by President Johnson to sign up as close to 100 per cent as possible to the California Physicians' Service. It was explained to them that it was extremely necessary. The members were also urged to pay their dues.

There being no further business to come before the Society, the meeting was declared adjourned at 10:30 p. m., and refreshments were then served.

G. H. Rohrbacher, *Secretary.*

⁂

SAN MATEO COUNTY

The meeting of the San Mateo County Medical Society was held in the banquet room of the Benjamin Franklin Hotel on Wednesday, February 22. Dr. Carl Benninghoven presided.

The Chairman announced that Dr. G. Franklin Shiels of Redwood City had been elected to honorary membership.

Doctor Benninghoven also mentioned the bill for Certification of Social Service Workers and announced that a report concerning the approval by the Society would be submitted upon word from the Legislative Committee of the California Medical Association.

The Secretary made an announcement concerning the immunization of children in the San Mateo schools and referred to the work of the Public Health Committee in the preparation of a satisfactory school health program for San Mateo County. The Secretary suggested that until this program is under way, and in view of the present emergency in connection with the smallpox outbreak in Redwood City, it might be best for the County Society to approve the previous method of immunization among school children and provide voluntary workers to carry out such immunization at a minimum schedule. He further announced that with the consent blank, which would be sent to the parents, a form would be submitted, consisting of educational propaganda directed toward emphasizing the importance of preschool immunization, and mentioning the possible harm that might result if the general public were to wait until the children were of school age to have immunization done.

In connection with the Postgraduate Conference, a list of various subjects was submitted to the Society to indicate its preference concerning subjects of first, second, and third desirability. The following subjects received the greatest number of votes, in this order: blood dyscrasias, endocrine problems, deficiency diseases and allergy. The Secretary announced that he would submit this information to the Committee on Postgraduate Conferences.

In connection with the prenatal and premarital tests for syphilis and gonorrhea, a motion was made, seconded and unanimously passed, that the endorsement of the program contained in the bill introduced into the Legislature by the Southern California Medical Society, for the control of syphilis and gonorrhea, be determined by the attitude of the California Medical Association.

An announcement was made concerning the availability of a piece of property in Burlingame for a combined office and residence for a physician.

The Secretary made a brief report on the question of health insurance and mentioned the propaganda that was being indulged in by the proponents of the Compulsory Health Insurance Bill, and the importance of a united front among the doctors: on the one hand, in support of the California Medical Association plan; and on the other hand, in opposition to the Compulsory Health Insurance measures. In connection with our own tactics, the Secretary referred to the distribution, which is to be made, of the Walch pamphlet, "On the Witness Stand," and also the advisability of a Speakers' Bureau of the county society, to provide speakers for public and organization meetings. The Secretary further announced, in this connection, that the membership of the Society would shortly be solicited by the California Physicians' Service for professional membership and urged that every doctor coöperate by taking out such membership.

The Chairman then introduced Dr. John W. Brown of the California University Medical School, who presented a very interesting discussion on the subject of *Pneumonia*, with special reference to serum therapy. Dr. L. B. Coblentz, a member of the Pneumonia Control Committee of the California Medical Association, was then introduced. He presented a paper on *Eleven Cases of Pneumococcic Pneumonia Treated with Sulfapyridin*. While he emphasized the fact that the results were not conclusive, the remarkable response to this type of therapy suggested a very considerable advance in the treatment of this disease. The Society enthusiastically expressed its appreciation to Doctor Brown and Doctor Coblentz for their exceptional presentations.

J. Garwood Bridgman, *Secretary*.

⁂

VENTURA COUNTY

The regular monthly meeting of the Ventura County Medical Society was held at the Saticoy Country Club on Tuesday, February 14. Eighteen members and three guests were present.

Former Judge Henderson spoke on *Common Medical-Legal Problems*. This was followed by a good discussion.

The applications of Dr. E. R. Sizor of Camarillo for membership, and Dr. H. F. Galbraith of Ventura for transfer from the Los Angeles County Medical Society were presented for the first time.

The following communications were read: From Dr. C. A. Dukes expressing his appreciation of the large attendance and good dinner at the special meeting. From the Cancer Commission in regard to the pathologic and x-ray conference, which was held on the Sunday before the State meeting. Letter from the Pneumonia Control Committee. Letter announcing the third mid-year conference of the secretaries. Letter from Doctor Schaupp, acknowledging our request for a unit of California Physicians' Service. From the committee in charge of a movement to install an iron lung in the Ventura County Hospital. From Mrs. T. E. Shelton, announcing the opening of the Shelton School in Ojai for children who need special care. From Café Royale in Ventura, inviting us to inspect their new clubroom.

The need for an iron lung at the County Hospital was discussed, but it was the consensus of opinion of the members present that there was less need for a machine of this type than for other equipment.

The local Tuberculosis Association asked what the attitude of the members would be in regard to helping with another survey of twelfth-grade pupils for tuberculosis. No definite action was taken in answer to this question, but it was felt by the majority of members present that this was either a problem for the School Board or the communities in general, and that physicians should not be asked to do this work without some compensation. It was suggested that the Tuberculosis Association approach the School Boards in those districts which do not have a full-time or part-time physician.

Mr. Whittaker of the Ventura Adjustment Company requested permission to form a medical-dental collection bureau, which would be sponsored by the Society. It was moved by Doctor Coffey, and seconded by Doctor Hendricks, that this request be tabled. Carried. It was brought out in discussion that the members felt that collections should be an individual problem and that the Society, as such, should not become involved.

The following Board of Censors was appointed: Doctors Coffey, Nielson, and Osborn.

Doctor Morrison was reappointed to the Public Health Advisory Committee.

A. A. Morrison, *Secretary*.

⁂

YUBA-SUTTER COUNTY

The regular meeting of the Yuba-Sutter County Medical Society was held at the Hotel Marysville on March 7 at 8:30 p. m. Dinner preceded the business and scientific part of the evening.

Members present were: Doctors Higgins, Miller, Hamilton, Wisner, Parkinson, Loomis, Swift, Thunen, Linstrum, Whitney, and Morris; associate member present, Doctor Richards. Visitors present: Dr. George M. Uhl of the

Department of Public Health Bureau of County Health Work and Dr. Paul J. Moses of San Francisco.

President P. E. Thunen called the meeting to order about 9:30 p. m.

Following the reading of the minutes and the reports from standing committees, Dr. Paul Moses of San Francisco presented a paper on *Voice and Speech Disorders.* He supplied each member present with an outlined copy of his talk. He illustrated his paper by the use of his own voice, and various instruments he had brought with him. An interesting discussion followed, showing that his subject was very well received.

President Thunen reported on the plan of a full-time public health unit, submitting correspondence from various county medical societies giving their opinions, reactions, and criticisms.

Dr. George M. Uhl discussed and replied to questions pertaining to the activities of a full-time public health unit. He advised a full-time public health unit for Yuba and Sutter counties, to be under the direction of a local physician trained in public health work. He stated that funds are available to assist the local counties in setting up a full-time public health unit.

The basic unit would consist of: full-time public health officer; public health nurses; sanitary inspector; and clerk.

The public health officer would be responsible directly to the County Board of Supervisors and be appointed by them according to law, but would work in coördination with the local medical society.

It was moved by Dr. Neal M. Loomis, and seconded by Dr. J. W. Lindstrum, that the Yuba-Sutter County Medical Society go on record as endorsing the establishment of a full-time public health unit to serve the whole of Yuba and Sutter counties. The motion carried.

President Thunen requested the public health officers of both counties to meet with the various clubs and organizations and influence them to favor the establishment of a full-time public health unit.

Dr. Leon M. Swift gave a report on the California Medical Association Secretarial Conference, which he attended in San Francisco on February 25, and discussed briefly the *California Physicians' Service,* and strongly urged each member to sign and mail his application immediately.

It was moved by Dr. Neal M. Loomis, and seconded by Dr. A. Lucian Hamilton, that we incorporate in the present fee schedule a minimum fee of $50 for one year well-baby service, exclusive of illness when physician is called to the home. The motion carried.

President Thunen informed Doctors Wisner and Linstrum, Sutter and Yuba county health officers, respectively, that the Yuba-Sutter County Medical Society has endorsed the establishment of a full-time public health unit.

President Thunen appointed Dr. Neal M. Loomis as the Postgraduate Committee.

Leon M. Swift, *Secretary.*

CHANGES IN MEMBERSHIP

New Members (72)

Alameda County

E. R. Jackson
Robert G. Libby
George V. Potter
Margery C. Shearer

Contra Costa County

W. S. Edmeades
E. C. Gerow
E. B. Todd

Fresno County

C. T. Swift
K. H. Taira

Kern County

J. E. Vaughan

Kings County

J. A. Crawshaw
F. W. Knight
Paul Murphy

Lassen-Plumas-Modoc County

Robert L. Moore

Los Angeles County

Ray L. Allison
Robert Benveniste
Selma C. Bolstad
C. H. H. Branvh
Francisco Bravo
E. S. Budge
S. Castanares
Morton Cole
Marvin B. Corlette
K. W. Delbridge
Hugh A. Edmondson
A. A. Finch
L. C. Grant
C. C. Hillyer
E. L. Hustead
Paul B. Kinney
Jean L. Lapeyre
F. B. Linne
J. M. Lynch
Port McWhorter
Harry F. Mershon
Robert M. Mullen
H. Plannette
David T. Proctor
Lloyd K. Rosenvold
A. G. Scheffel
L. J. Tragerman
Arthur G. Tullar
Lorenz M. Walker
Charles W. Ware
Hugo Weinberg
Herman Weiss
Julian O. Welke

Napa County

Walter H. Brignoli

Orange County

George Clark

San Bernardino County

Clarence T. Halburg, Jr.
Carroll A. Hermann
Herbert Piercy Nottage

San Diego County

Millard E. Gump
F. G. Hollander
Chester Tancredi
J. W. Thomas

San Francisco County

Arthur J. Abramson
Marie Behm
Yale Brody
Charles Edwin Cooper
Joseph A. Daniele
Avis E. Eaton
Rubin L. Gold
Peter J. Keenan
S. Frederick Long
Harold H. Marquis
Kurt Neugarten
Werner Proesch
Robert W. Wolf
Ernst Wolfes

Santa Clara County

Benno Safier
Denniston Wood, Jr.

Transferred (9)

A. G. Badami, from Santa Cruz County to Santa Clara County.

Lloyd Burrows, from Los Angeles County to Orange County.

E. W. Cleary, from San Francisco County to San Mateo County.

George C. Esker, Jr., from San Francisco County to Los Angeles County.

Harold F. Galbraith, from Los Angeles County to Ventura County.

Edward S. Lodge, from Los Angeles County to Orange County.

A. C. Pattison, from Fresno County to Los Angeles County.

Robert P. Quirmbach, from San Francisco County to Los Angeles County.

George W. Waters, from San Francisco County to Santa Clara County.

Resigned (3)

William H. Heinzman, from San Francisco County.

Seth H. Savage, from Los Angeles County.

W. Parker Stowe, from San Francisco County.

In Memoriam

Bathurst, Edwin William. Died at Etna, March 9. 1939, age 85. Graduate of Cooper Medical College, San Francisco, 1877, and licensed in California the same year. Doctor Bathurst was a retired member of the Siskiyou County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

✢

Lumley, Clinton Grant. Died at Huntington Park, February 17, 1939, age 77. Graduate of Northwestern University Medical School, Chicago, 1889. Licensed in California in 1929. Doctor Lumley was a member of the Los Angeles County Medical Association, the California Medical Association, and the American Medical Association.

✢

Scheier, Ralph Bartholomew. Died at San Francisco, February 25, 1939, age 59. Graduate of College of Physicians and Surgeons, San Francisco, 1908, and licensed in California the same year. Doctor Scheier was a member of the San Francisco County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

✢

OBITUARIES

George Benjamin Henke

1884–1939

At four o'clock on Wednesday afternoon, January 25, 1939, Dr. George Benjamin Henke died suddenly from coronary occlusion at his home, 1458 North Euclid Avenue, Ontario.

In 1913 Doctor Henke settled in Ontario, and for twenty-five years had been active in the affairs of the community. He was a member of the San Bernardino County Medical Society, State Medical Association, the American Medical Association, the Southern California Medical Association, and of the board of directors of the San Antonio Community Hospital.

Doctor Henke led a very active life. His forceful personality, unusual diagnostic ability and timely advice endeared him to all who were privileged to know him. He was untiring in his devotion and service to his patients, and few men have ever enjoyed the loyalty, esteem and affection of their patients as did Doctor Henke. In his passing his patients have lost a real friend and family physician, and the community has lost a much beloved and highly respected citizen.

Robert C. Nichols, M. D.

✢

William Allan Taltavall

1858–1938

Dr. William Allan Taltavall was born on November 28, 1858, in North Shields, Northumberland, England, of Spanish and Scotch parentage. The family, including four small sons, came to the United States in 1863 and settled in Cleveland, Ohio.

Doctor Taltavall entered Harvard University in 1877, but failing health forced him to leave in his sophomore year. He spent some time recuperating in the South, and entered the College of Physicians and Surgeons at Columbia University in 1881 and was graduated from it in 1884.

He began the practice of medicine in New York City, and was later associated with the Rockefeller Institute. Married in 1885, he removed to Redlands, California, in 1903, on account of his wife's failing health. She died here in 1904, and their only daughter in 1907.

Doctor Taltavall's profound knowledge of pathology and medicine was always an inspiration, and his ability in laboratory procedures was recognized all over the state. His sterling qualities as a man and his unflinching steadfastness as a true friend were truly appreciated by all of us who knew him.

His passing, on December 21, 1938, makes one more break in the ranks of the men who made early medical history in the county of San Bernardino, and leaves a deep heartache for his loss in those of us who were privileged to be his friend.

Carlos G. Hilliard, M. D.

✢

Ralph B. Schier

1880–1939

At the age of fifty-nine years Doctor Schier was taken from our midst after a year attended with great suffering combined with unusual fortitude.

Doctor Schier was graduated from the University of California Medical School in 1908, following this with a few years of general practice. He then prepared for the specialty of diseases of the lungs, and founded the Canyon Sanitarium in Redwood City, of which he was medical director until his death. He was one of the first to make it possible for people of moderate circumstances to have institutional care. Many patients will testify as to the financial, physical and moral help they received through his cheerful personality and professional care. Many of his colleagues will miss his staunch friendship and the stimulating character of his conversation. He is survived by his widow, and a son and daughter.

Lawrence H. Hoffman, M. D.

✢

Edwin W. Bathurst

1854–1939

Edwin W. Bathurst was born in Australia on April 30, 1854, and died following a cerebral accident on March 9, 1939.

He had his preliminary education in Australia, and entered a French hospital on the island of New Caledonia, in the South Seas, and became much interested in medicine there. He then came to San Francisco, California, entering Stanford University, graduating in the class of 1877. He started practice at Sawyers Bar, California, at the time when it was a gold camp. Practice was on horseback, and he went through several severe diphtheria epidemics before antitoxin was known, and at a time when a crude tracheotomy set was a much used instrument in every physician's saddlebag. Calls two days long were a common thing in that mountainous country. In 1882, Doctor Bathurst moved to Etna, Siskiyou County, California, where he carried on an active practice until his death. He was a charter member of the original Siskiyou County Medical Society in 1888, and has been an active member in the same society since. He played an active part in the civic improvement of his district, serving as school board president, mayor of Etna, and a member of the County Board of Supervisors. In his sixty-two years of practice, Doctor Bathurst spanned the time from the period when the germ theory disease was a controversial point and antiseptic surgery was unknown to the period of modern medicine, and kept abreast during that entire period. He understood the art of the practice of medicine. He was a loyal friend to his patients, and leaves a place in his community that will be difficult to fill.

V. W. Hart.

THE WOMAN'S AUXILIARY TO THE CALIFORNIA MEDICAL ASSOCIATION†

MRS. CLIFFORD A. WRIGHT..................................President
MRS. FRED H. ZUMWALT..............Chairman on Publicity
MRS. FRANK H. RODIN..Assistant Chairman on Publicity

News Letter

Dear Auxiliary Members:

The 1939 annual convention of the California Medical Association and the Woman's Auxiliary will be held in beautiful Del Monte from Sunday, April 30, to and including Thursday, May 4.

The rates for accommodation were published in the February issue of California and Western Medicine.

It is hoped that you have already made reservations and are planning to attend the session; if not, please do so at once.

The convention committee has been busy planning for your entertainment, comfort and interest, and its members are waiting to welcome you. Please come—you will enjoy every minute of your visit.

Sincerely yours,
Mrs. Frank H. Rodin.

Component County Auxiliaries

Alameda County

The Woman's Auxiliary to the Alameda County Medical Association met for luncheon on Friday, March 17, at the Clairmont Country Club. The president, Mrs. Frank Baxter, presided.

Mrs. I. O. Church, Program Chairman, introduced Mr. Claud A. Shaull, President of the San Francisco Motion Picture Council and a member of the faculty of the San Francisco State College, who spoke on *Society's Stake in Motion Pictures.*

Mr. George U. Wood, Manager of the Peralta Hospital, showed a motion-picture film, entitled *Behind the Scenes in a Modern Hospital.*

The hostess of the day was Mrs. Thomas A. Clark, a former president of the Alameda County and California State Auxiliaries.

Mrs. Grant H. Ellis, *Publicity Chairman.*

⁂

Fresno County

The annual public health meeting, sponsored by the Woman's Auxiliary to the Fresno County Medical Society, was held on March 10 in the Administration Building of the Fresno public schools.

Mrs. J. R. Walker, Chairman of Public Relations, introduced Dr. William N. Anderson, heart specialist of Los Angeles, who spoke on *Living with a Damaged Heart.*

There was a very good attendance, and the audience was intensely interested in the subject.

Mrs. Charles H. Ingram, *Publicity Chairman.*

⁂

Los Angeles County

The members of the Woman's Auxiliary to the Los Angeles County Medical Society met on February 28 in the beautiful Gothic dining room of the Pacific Coast Club, overlooking the ocean in Long Beach. One hundred and forty-two members and guests attended the luncheon and meeting. In the absence of the president, Mrs. William H. Leake, the vice-president, Mrs. William Boeck, presided.

Mrs. Ralph B. Eusden, Program Chairman, introduced Dr. Lowell S. Goin, Speaker of the House of Delegates of the California Medical Association. Doctor Goin spoke on the *Health Insurance Plan of the California Medical Association.*

Mr. Ben Read, Executive Secretary of the California Public Health League. spoke on *Legislation Affecting Medicine,* and emphasized the fact that there were 203 measures pertaining to medicine before the Legislature in Sacramento this year. Mr. Read asked the members to study Assembly Bill 2172 and Senate Bill 1128 on Compulsory Health Insurance.

Dr. Charles Debby of Kansas City, Missouri, spoke on the *Federal Plan for Health Insurance* and pointed out his reasons for opposing such a plan.

Mrs. Karl Von Hagen, *Publicity Chairman.*

⁂

Marin County

The Woman's Auxiliary to the Marin County Medical Society met for dinner on February 23 at the Sleepy Hollow Country Club.

The Board members met a short time before the dinner hour and took up the matter of the State convention in Del Monte.

After dinner the president, Mrs. B. J. Conroy, introduced the guest speaker, Dr. Frederick A. Fender of San Francisco, whose subject was *Neurosurgery.* Doctor Fender's talk was instructive and interesting, as he described operations for brain tumors and those necessitated by injuries.

Mrs. C. A. DeLancy, *Publicity Chairman.*

⁂

San Diego County

The annual benefit bridge party given by the Woman's Auxiliary to the San Diego County Medical Society was a great success, both financially and socially. It was held on Valentine's Day, February 14.

Seven homes throughout the city were opened for the occasion, with an attendance of three hundred members and guests. Tables and tallies, as well as the delicious desert of raspberry ice cream and white merangues, carried the Valentine motif.

The funds collected will be used for health education for the public in the community and for philanthropic activities.

The hostesses were Mesdames Frazer MacPherson, Charles W. Brown, David Higbee, James Reeves, W. C. Cooke and Lloyd Meyers of San Diego, and Mrs. W. L. Garth of La Jolla.

Mrs. H. K. Albertson, *Publicity Chairman.*

⁂

San Luis Obispo County

The members of the Woman's Auxiliary to the San Luis Obispo County Medical Association met for dinner on February 18. The president, Mrs. Charles P. Kennedy, presided, with eight members and two guests in attendance.

Mrs. Kennedy reported on her visit as a guest to the State Board meeting of the Woman's Auxiliary held in San Francisco on February 17. Three new members were welcomed to the Auxiliary.

The members expressed deep sympathy at the death of Dr. A. H. Giliahan, who passed away on February 15. Doctor Giliahan was a close friend of the Auxiliary, having assisted with its organization, and was a member of the first Advisory Committee.

The County Health Department requested the aid of the Woman's Auxiliary in the clinic to be held for crippled children. It was voted that the members will assist in every way possible.

Mrs. Charles Kennedy, *President.*

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† As county auxiliaries of the Woman's Auxiliary to the California Medical Association are formed, the names of their officers should be forwarded to Mrs. Frank H. Rodin, Assistant Chairman of the Publicity and Publications Committee, 2457 Bay Street, San Francisco. Brief reports of county auxiliary meetings will be welcomed by Mrs. Rodin and must be sent to her before publication takes place in this column. For lists of state and county officers, see advertising page 6. The Council of the California Medical Association has instructed the Editor to allocate two pages in every issue to Woman's Auxiliary notes.

Santa Barbara County

Mrs. Harold G. Trimble of Oakland, State Chairman of *Hygeia*, was the honored guest at a special luncheon meeting held by the Woman's Auxiliary to the Santa Barbara County Medical Society on February 27 at the El Paseo.

After luncheon, Mrs. Trimble spoke of *The Importance of the Hygeia Health Magazine*. She also presented ways and means for developing a large circulation in the community.

During the short business meeting that followed, the membership voted to send $5 to the *Courier*.

MRS. C. W. HENDERSON, *Publicity Chairman*.

⁂

Santa Clara County

The members of the Woman's Auxiliary to the Santa Clara County Medical Society met at the Sainte Claire Hotel for luncheon on March 6. The president, Mrs. Morgan D. Baker, presided.

The guest speaker was Mrs. Theodore Lee of Berkeley, who gave a most interesting talk on *Medicine in Other Times and Places*. Beginning with her childhood recollections, many years ago, in Western Pennsylvania, Mrs. Lee told of the doctor making calls on horseback, carrying his meager equipment in leather saddlebags, and traveling over lonely trails that connected the sparsely settled community. Then to a small town in Utah, giving a vivid picture of the life among the Mormons and the difficulty the doctors had, because the Mormons at that time did not believe in medical care. And, in conclusion, compared the medicine of the present day, its specialization, and modern equipment. Mrs. Lee also told of medical work done by members of her family in far-off Persia.

May 10 is the date set for the silver tea to be given at the home of Mrs. R. S. Kneeshaw. The funds collected are to be used to send as many children as possible to camp this summer.

Mrs. Leslie Magoon will be in charge of arrangements for a barbeque to be given at the Los Altos Country Club, at which time the husbands will be the guests of the Auxiliary members.

MRS. CHARLES MOORE, *Publicity Chairman*.

⁂

Santa Cruz County

The Woman's Auxiliary to the Santa Cruz County Medical Society met for luncheon at the Pasatiempo Country Club on February 27. The president, Mrs. Alfred L. Phillips, presided.

Mrs. F. P. Shenk reported on the cancer control meeting held in San Francisco. Upon the advice of the Advisory Committee, the members will give publicity to the importance of medical care in cancer control, but will not join at present.

Mrs. N. Sullivan presented a paper on *Socialized Medicine*, and Mrs. A. Pederson described the plans for health insurance as offered by the California Medical Association.

MRS. R. C. ALSBERG, *Publicity Chairman*.

Proposed Amendment

The following is the proposed amendment to Section 1 of Article 9 of the Constitution of the Woman's Auxiliary to the California Medical Association:

SECTION 1

For the years 1939 and 1940 to 1941 the Nominating Committees, each consisting of five members, shall be appointed at the annual meeting held in May, 1939. Each committee shall consist of five members, two of whom shall be elected by the Board of Directors, and three to be members-at-large, elected by the House of Delegates. The members elected by the Board of Directors shall be elected at the regular meeting held previous to the annual meeting, while the members elected by the House of Delegates shall be elected at the first session of the annual convention. The Board of Directors shall designate the chairman of each committee. The Nominating Committee so elected for 1939 to 1940 shall present its report of nominees as soon as possible. The nominating committee so elected for 1940 to 1941 shall meet sixty days prior to the annual meeting of 1940 and prepare its report and submit the same at the first session of the annual meeting in 1940.

Beginning with the annual meeting in 1940, and annually thereafter, the Nominating Committee shall be appointed each year in advance and shall consist of five members, two elected by the Board of Directors and three to be members-at-large, elected by the House of Delegates.

It shall be the duty of the Nominating Committee to nominate and present in the regular order of business, candidates for the following offices: president-elect, first vice-president, second vice-president, recording secretary, treasurer, and four councilors-at-large to serve for one year or until their successors assume office.

ESTHER TRIMBLE.
(Mrs. Harold G.)

Carditis.—An aid in determining the duration of convalescence and the diagnosis of active carditis (inflammation of the heart) following attacks of rheumatic fever was recently described by the United States Public Health Service in its weekly bulletin, *Public Health Reports*.

The observations reported in the study, according to Dr. Mark P. Schultz, surgeon, and Edythe J. Rose, associate bacteriologist, "were made with the object of determining the significance of alterations in the 'formol-gel reaction' in febrile diseases, particularly rheumatic fever." Only blood serum from patients is required for the reaction, they pointed out, and the test may be performed several days after the specimen is collected.

Rheumatic fever, chief cause of heart disease in children, is frequently a chronic and insidious process. The most effective treatment known is complete rest in bed until the inflammation in the heart has completely subsided.

"Notwithstanding the several diagnostic criteria available, however," said the researchers, "it is often very difficult for the physician to decide when, during the long period of convalesence, activity of the disease terminates. There is the possibility, on the one hand, that the child will be kept flat in bed needlessly for months; on the other, that he will be allowed to get up prematurely and thereby incur serious damage to his heart."

The experiments described by the authors would imply that an additional aid in making the decision with respect to the ocurrence of complete recovery may be available. If a drop of formaldehyde solution is added to a small amount of blood serum from the patient and no change takes place in the liquid during the next twenty-four hours, suggestive evidence is provided that activity of the disease has subsided. If, however, the serum becomes "jellied" or cloudy, it is a definite indication that rest in bed should be continued.

Of the seventy rheumatic fever patients used in these experiments, thirty-three developed strongly positive formol-gel reactions during the course of observation. In the remainder, only negative or faintly positive reactions were obtained, and these for the most part were mild cases.

"These observations suggest," the authors conclude, "that the reaction may be a valuable additional aid in determining the presence of active rheumatic carditis in patients known to be suffering from rheumatic fever. Strongly positive reactions in children, or in adults without arthritis, suggest the presence of active carditis; negative results, on the other hand, indicate the absence of severe carditis, and are of favorable diagnostic import."

There are two things in life that a sage must preserve at every sacrifice, the coats of his stomach, and the enamel of his teeth. Some evils admit of consolations, but there are no comforters for dyspepsia and the toothache.—Bulwer.

MISCELLANY

Under this department are ordinarily grouped: News Items; Letters; Special Articles; Twenty-five Years Ago column; California Board of Medical Examiners; and other columns as occasion may warrant. Items for the News column must be furnished by the fifteenth of the preceding month. For Book Reviews, see index on the front cover, under Miscellany.

NEWS

Coming Meetings

American Medical Association, St. Louis, Missouri, May 15 to 19, 1939. Olin West, M. D., Secretary, 535 North Dearborn Street, Chicago, Illinois.

California Medical Association, Hotel Del Monte, May 1 to 4, 1939. George H. Kress, M. D., Secretary, 450 Sutter Street, San Francisco.

Nevada Medical Association, Reno, September 22 and 23, 1939. Horace J. Brown, M. D., Secretary, P. O. Box 689, Reno, Nevada.

Medical Broadcasts*

Los Angeles County Medical Association

The radio broadcast program for the Los Angeles County Medical Association for the month of April is as follows:

Saturday, April 1—KFI, 9:00 a. m., The Road of Health; KFAC, 11:30 a. m., Your Doctor and You.
Thursday, April 6—KECA, 10:45 a. m., The Road of Health.
Saturday, April 8—KFI, 9:00 a. m., The Road of Health; KFAC, 11:30 a. m., Your Doctor and You.
Thursday, April 13—KECA, 10:45 a. m., The Road of Health.
Saturday, April 15—KFI, 8:00 a. m., The Road of Health; KFAC, 11:30 a. m., Your Doctor and You.
Thursday, April 20—KECA, 10:45 a. m., The Road of Health.
Saturday, April 22—KFI, 9:00 a. m., The Road of Health; KFAC, 11:30 a. m., Your Doctor and You.
Thursday, April 27—KECA, 10:45 a. m., The Road of Health.
Saturday, April 29—KFI, 9:00 a. m., The Road of Health; KFAC, 11:30 a. m., Your Doctor and You.

Postgraduate Courses on Maternal Care.†—The Committee on Postgraduate Work of the California Medical Association, in coöperation with the State Department of Public Health, announces that Dr. Harold Teel will be in California for a period of six weeks during April and the first part of May. One of the chief purposes of Doctor Teel's visit will be to conduct a course of lectures at the University of California. In addition, county medical societies will be given an opportunity to arrange for lectures on recent developments in maternal care.

Doctor Teel is a Californian, having taken his undergraduate work at the University of California. He received his degree of doctor of medicine from the Harvard School of Medicine, where he is now an assistant professor of obstetrics.

Besides his teaching and experience in private practice, Doctor Teel has been associated with Dr. Harvey Cushing. The visiting lecturer is at present on the staff of the Lying-In Hospital, Boston. He is also a Fellow of the American Medical Association.

Since Doctor Teel's stay in California will be of short duration, those county medical societies desiring to avail themselves of the opportunity of hearing Doctor Teel should communicate at once with the secretary of the California Medical Association, 450 Sutter Street, who is also secretary of the California Medical Association Postgraduate Committee, so that proper arrangements for a clinical conference may be made.

Alpha Epsilon Delta.—The Nevada Alpha Chapter of Alpha Epsilon Delta, honorary premedical fraternity, observed National Social Hygiene Day by holding an open meeting for the student body of the University of Nevada. Dr. B. H. Caples, Director of the Division of Venereal Diseases, opened the program by enumerating a few of the statistics on syphilis and gonorrhea for the State of Nevada. Dr. Lawrence Parsons, chief pathologist of St. Mary's Hospital, gave a direct and educational talk concerning the control and treatment of syphilis and gonorrhea. Dr. Peter Fransden closed the meeting by urging all students to take the Wassermann tests which were being conducted at the state hygiene laboratory, under the sponsorship of the Nevada chapter of Alpha Epsilon Delta.

The National Health Council.—The reëlection of Ira V. Hiscock, Professor of Public Health in the Yale University School of Medicine, as president of the National Health Council for 1939, has been announced by Thomas C. Edwards, Assistant Secretary of the Council.

Other officers of the National Health Council, with headquarters at 50 West Fiftieth Street, New York City, all of whom have been reëlected, are: Vice-President, Dr. Walter Clarke, Executive Director of the American Social Hygiene Association; secretary, Miss Dorothy Deming, General Director of the National Organization for Public Health Nursing; treasurer, Mr. Frederick Osborn, Secretary-Treasurer of the American Eugenics Society.

The following new members have been elected to the Board of Directors for a three-year period: Dr. Thomas Parran, Surgeon-General, United States Public Health Service; Dr. Martha M. Eliot, Assistant Chief, United States Children's Bureau; Dr. Edmund P. Fowler, President, American Society for the Hard of Hearing.

Premarital Legislation.—Twenty-six states have enacted laws in an attempt to protect the marital relationship from the ravages of venereal disease.

Connecticut, Illinois, Michigan, Wisconsin, New Hampshire, Kentucky, New York, Rhode Island, Oregon, and New Jersey require that both male and female applicants for marriage licenses must present medical certificates showing that both are either entirely free from syphilis or, in some states, free from infectious syphilis. Certain states of this group (Illinois, Kentucky, and Michigan) require that applicants be free from all venereal disease. In all ten of these states, laboratory tests are required.

Alabama, Louisiana, North Dakota, Texas, and Wyoming require only the male to present a medical certificate stating that he is free from all venereal disease. North Dakota and Wyoming specify that the disease must not be in a communicable stage.

California, Delaware, Indiana, Maine, Nebraska, North Carolina, Oklahoma, Pennsylvania, Utah, Vermont, and Virginia do not require medical certificates, but require personal affidavits from both male and female applicants of their freedom from all venereal disease; or they try in various other ways to discourage the marriage of those venereally infected. These states do not specify medical examination as a prerequisite to obtaining a license.

New York, New Jersey, and Rhode Island require that all doctors and midwives make or cause to be made a blood test on every pregnant woman who comes to them for prenatal care.

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* County societies giving medical broadcasts are requested to send information as soon as arranged (stating station, day, date and hour, and subject) to CALIFORNIA AND WESTERN MEDICINE, 450 Sutter Street, San Francisco, for inclusion in this column.

† See tentative program of places and dates of clinical conferences on page 288.

University of California Medical School to Hold Charter Day Clinics.—The seventy-fifth Charter anniversary of the University of California was observed on Wednesday, March 22, by the University Medical Center by an Alumni Day, in which physicians and surgeons from all parts of the state participated.

The morning was given over to demonstration clinics by the medical, surgical and pediatrics staffs and operative clinics in surgery, obstetrics and gynecology.

In the afternoon the meeting departed from the usual routine of lectures and provided the visitors with a sightseeing tour of the medical school campus, with senior students acting as guides.

Popular Medical Lectures: Stanford University.—The Stanford University School of Medicine announces the fifty-seventh course of Popular Medical Lectures (illustrated), to be given at Lane Hall, north side of Sacramento Street, near Webster, on Friday evenings, on April 7, April 21, May 5, and May 19, 1939, eight o'clock sharp.

The subjects follow:

April 7—Pneumonia and Its Treatment by Recent Serums and Drugs, by Edwin L. Bruck, M. D.

April 21—Electrical Engineers Come to the Aid of the Hard of Hearing, by Harold A. Fletcher, M. D.

May 5—What Are the Movies Doing to the Emotional Stability of Our Children? by Claude A. Schull, M. A.

May 19—Emotions and Physical Diseases, by Paul A. Gliebe, M. D.

All interested are cordially invited to attend.

Smallpox Situation.—The Department of Public Health of the City and County of San Francisco, in a bulletin dated March 14, 1939, stated:

> In 1933–1937, a period of five years, only one case of smallpox was reported in San Francisco that might have received the infection locally. If the infection occurred locally, it was because of contact with another case that came from outside sources.
>
> During the same period, eleven cases occurred in San Francisco which received their infection from outside sources and may be considered "imported cases."
>
> In 1938 a similar condition occurred, in which three cases were reported in San Francisco, two being acquired locally and one receiving its infection from outside the city.
>
> To summarize: In the period of six years, three cases received the infection from local sources and twelve received infection from outside sources, or were "imported" cases into San Francisco.
>
> In the matter of smallpox in 1939, however, it appears that a definite increase in cases may be expected. For instance, in the State of California in 1936 there were reported 1,266 cases, but since January 1, 1939, the number of cases reported have been 219. It could be assumed from these figures that smallpox is increasing within the state. Counties adjacent to San Francisco are reporting definite outbreaks of smallpox. The County Health Officer of San Mateo County, Dr. Charles Gans, reported eighteen cases to date, presumably in the Redwood City area. Sacramento County reports sixty-four cases to date, the majority of cases being confined to itinerant groups which are wandering throughout the state. Therefore, the Department of Public Health of the City and County of San Francisco is urging increased smallpox vaccination in the schools, increased vaccination against smallpox in all child health centers; increased vaccination against smallpox in every medical clinic in San Francisco, including the Central Medical Bureau. Lastly, it is urged that the practicing physicians of the city and county of San Francisco increase vaccination against smallpox and observe very carefully every rash that appears in order that the possibility of smallpox be completely eliminated. All superintendents of hospitals are requested to check carefully vaccination status of their patients. Likewise, all epidemiologists of the Department of Public Health must check every reported case of chickenpox for final diagnosis.
>
> Although San Francisco may be considered singularly free of cases of smallpox at this time, and likewise be a highly successfully vaccinated community, it is necessary that all precautions be taken to avoid an increase of this disease.

University of California Medical School: Invitation to Clinics.—Physicians visiting the Golden Gate International Exposition will be welcomed at the University of California Medical School, Parnassus and Fourth avenues, San Francisco. Department rounds are open to them. Except during the summer vacation, May 13 to August 21, these are held at nine o'clock in Toland Hall, first floor, University Hospital, as follows: Tuesdays, gynecology and obstetrics; Wednesdays, medicine; Thursdays, pediatrics; Fridays, surgery. Visitors are also invited to use the Crummer Medical History Library and the other facilities of the School.

Western Branch, Society American Urological Association.—The Western Branch, Society American Urological Association will hold its annual meeting for 1939 at Del Monte, on April 27, 28, and 29.

Under the presidency of Dr. George G. Reinle, the Society will present perhaps the best rounded-out program in its history.

There will be a symposium on the new sex hormones, with special reference to testosterone propionate, in which scientists and clinicians from the East will participate; there will also be one on renal calculi. Hyperpyrexia will be discussed. A résumé of the urological literature for 1938 will be presented.

There will be a comprehensive scientific exhibit of slides, specimens, and x-rays; and also a technical exhibit showing the newest developments in drugs, appliances, and furniture, of interest to urologists.

The meeting will be open to all members. Nonmembers are invited to make application for guest cards at the registration desk.

Family Relations Center.—From time to time physicians refer patients to the library of the Family Relations Center at 1200 Hyde Street, San Francisco, Telephone ORdway 9976, for books relating to marriage and sex education. To assist the busy physician in making recommendations to his patients, the Center suggests a few titles of what it believes to be the best and most readable volumes now available.

For married persons or those preparing for marriage, Oliver M. Butterfield's book, "Sex Life in Marriage," and Millard S. Everett's "Hygiene of Marriage," are reliable, and lay readers have found them very satisfactory. "Sex Life in Marriage" is the simpler and more easily read of the two, while "Hygiene of Marriage" is superior where the physician wishes to suggest a single volume on marriage, embodying an adequate discussion of contraception. "Emotional Adjustment in Marriage," by Dr. LeMon Clark, serves as an excellent companion to either Butterfield or Everett. It is probably the best present-day book dealing with the emotional aspects of marriage.

For the adolescent, "Life and Growth" by Alice Keliher, explains both the physiology and psychology of sex and adolescent development more satisfactorily than any other volume. It is published by the Progressive Education Association as a textbook for use in high schools. "The Story of Sex" by Helena Wright is a simply written explanation of sex and reproduction which may be helpful to those who would not read a textbook like "Life and Growth."

Perhaps the best thing available for the very young child is "Growing Up," by Karl de Schweinitz. It tells the story of reproduction simply for the child from five to eight years of age. "Being Born" by Frances Strain is an excellent book of the same type for children from nine to twelve.

For parents who find it difficult to discuss questions pertaining to sex and reproduction with their children, "New Patterns in Sex Training" by Frances Strain, and "Sex Education of Children" by Mary Ware Dennett, are reliable and helpful volumes.

Fungus Disease.—A study of the causative factor of coccidioidal granuloma is being made in the department of dermatology of the University of California Medical School, under the direction of Dr. Robert A. Stewart. Through the study it is hoped to determine enough of the nature of this disease to aid in the development of more satisfactory treatment than exists at the present time. Only the most drastic methods can now be employed in combating the disease and, despite these, the known mortality is in excess of 50 per cent.

The disease was first reported in Buenos Aires in 1892 and in this country four years later. It was first identified by Dr. Emmett Rixford, a San Francisco physician, working in coöperation with Doctor Gilcrist of Johns Hopkins. The causative organism was found to be a fungus or mold, instead of the more familiar protozoan or animal type of organism. In 1928 it was shown that the fungus was present in cattle and sheep. From this finding Doctor Stewart was enabled to determine that the Coccidioides grows and flourishes on grass, potatoes, carrots, cactus, and pieces of decayed wood.

When first reported, the disease had a mortality of 100 per cent, but the identification of a milder form was made later.

Society of Medical Friends of Wine.—Seventy-eight members of the medical profession of San Francisco have organized a society for an objective new to the United States—the study and appreciation of wine. The new organization is named "The Society of Medical Friends of Wine," and officially began its existence with an inaugural dinner held at the St. Francis Yacht Club, San Francisco, on February 24.

It is described officially as follows:

"The object of the Society of Medical Friends of Wine is to stimulate scientific research on wine, develop an understanding of its beneficial effects, and encourage an appreciation of the conviviality and good fellowship that are part of the relaxed and deliberate manner of living that follows its proper use."

Officers chosen to serve during the coming year are as follows: Dr. Charles P. Mathé, president; Dr. Thomas F. Mullen, vice-president; Dr. Randolph G. Flood, secretary; Dr. Marcis A. Francoz, treasurer. Executive Committee: Doctors Harry E. Alderson, Rae E. Ashley, Lloyd B. Crow, Marius A. Francoz, Chauncey D. Leake, Salvatore P. Lucia, Charles P. Mathé, Herbert C. Moffitt, Thomas F. Mullen, Langley Porter, and Rodney A. Yoell.

The inaugural dinner exemplified the purposes of the Society, by devoting the principal discussions to the foods and wines especially selected for the menu. California wines of various vineyards were served. Dr. Edward W. Twitchell, Professor of Psychiatry of the University of California Medical School, addressed the dinner on "How the Doctor Looks at Wine."

Dr. Maynard A. Amerine, Assistant Professor of Enology of the University of California, Department of Viticulture, informally explained the various wines served and answered numerous questions asked by the attending physicians.

Honored guests of the Society were: Dr. Enrique Finochietto, Professor of Surgery, University of Buenos Aires, and Dr. Jorge Mulcahy, Chief Surgeon, Hospital Britanico, also of Buenos Aires.

While the Society is new to America, it follows a precedent set many years ago in France, where, under the leadership of Dr. Georges Portmann, Professor of Medicine of the University of Bordeaux, members of the medical profession have a number of such societies. International congresses of European physicians interested in wine have been held under the title of "Congres International des Médecins amis du vin."

Malarial Inoculation for Syphilis: California Department of Institutions.—In a large percentage of cases of syphilis—more particularly those in which there has been failure of early diagnosis and prompt and thorough treatment—the infection involves the brain and other parts of the central nervous system. Such cases often lead eventually to incurable mental disease. Nearly 7 per cent of all admissions to the mental hospitals of California consist of cases of syphilitic brain disease—for the most part the disease known as paresis. In actual numbers, between 400 and 500 such cases are admitted to the state hospitals annually.

The splendid work that is now being done on a rapidly expanding scale by our federal, state, county, and municipal health departments along the lines of venereal disease control should soon yield demonstrable results in the form of reduction of our admission rates of cases of syphilitic insanity. There is, however, one preventive measure that has heretofore not been adequately provided for, namely, the fever treatment (by malarial inoculation) for those cases of syphilis in which there is evidence of involvement of the central nervous system and in which there is, therefore, a danger of the eventual development of paresis unless the fever treatment is instituted before the mental deterioration sets in, which is due to destruction of nervous tissues accompanying the progress of the syphilitic brain disease.

The Department of Institutions of the State of California, through its director, Aaron J. Rosanoff, announces that henceforth treatment by means of malarial inoculation will be available for all suitable cases in the following State hospitals: Agnews, Camarillo, Mendocino, Napa, Norwalk, Patton, and Stockton.

Patients referred to any of these hospitals by any health officer or, through a health officer, by a private physician, as requiring a malarial inoculation may receive such inoculation at the hospital. Thereupon, such patients may immediately return to their homes, or to private hospitals or sanitariums, there to remain under the care of their private physicians during the course of their fever. Patients who cannot afford private care will be admitted to the State hospitals, for the fever period, upon their voluntary application. In many cases of syphilis, timely fever treatment alone can prevent the eventual development of paresis.

California Pharmaceutical Association.—This association, with offices in the H. W. Hellman Building, 356 South Spring Street, Los Angeles, in its Bulletin of March 15, 1939, printed the following:

> *Medical Service Benefit Associations May Enter Orgy of Cut-Rate Competition*
>
> The doctors may suffer and muddle through an era of the same type of cut-throat competition which has harassed druggists for a quarter century. Because the druggist sells merchandise so intimately connected with public health, he has, after years of struggle, succeeded in passing laws limiting competition to a plane of ordinary decency.
>
> In this respect the doctor is handicapped, since he sells only his service, and the lessening or increase of the quality of service being an intangible thing, legislation to place a minimum price upon service would be difficult. That the doctors have long realized this and were forced, as a defensive measure, to establish a code of ethics to preserve for themselves a modicum of fairness in competition and the assurance of a reasonable recompense for their services, is well understood.
>
> They have merely attempted, through self-regulation, to do for themselves what legislative action could not do. Now, because of that, they are accused of being a trust, of being callous to public welfare and, by one publication of wide distribution, of being "hogs." It is to be noted that the loudest accusers of organized medicine are the types of organized group practitioners who, themselves, profit extensively from the operation of benefit associations and who, under the pious proclamation of "Social Good," pillory the profession which they have let down, to go into the cut-rate business.
>
> There is an analogy quite similar to that existing in the drug business. The cut-throat predatory seller sold stand-

ard drugs at ridiculous prices to get them into his store and then, from the contacts established, gave the customer the "works," holding the established pharmacist up to ridicule as a hold-up artist, when in reality he was giving value received in the practice of real pharmacy and doing a splendid job as a health service center in his community.

If the doctors are to be declared a trust and their heretofore defense ethics thrown overboard, and because theirs is a service profession where legislative protection against unfair competition is difficult, it may be that they will have to enter a period of severe competition, a period of such bitterness that the public itself, although in most instances a patron of the predatory seller, will be forced to call a halt and seek to restore "ethics" in the profession.

The pharmacists' interest and sympathy definitely allies itself with the physician in the struggle to commercialize and prostitute the profession through the use of multiple red herrings bearing such euphonious names as "Social Welfare," "Care of Underprivileged," "Ill Nourished," etc. If the cacophonous antonyms were applied to these same red herrings, they would bear such labels as: "Privileged Classes," "Private Welfare," "Political Power," etc.

Doctors, the pharmacists are ready to work with you to preserve the practice of medicine. Give them the opportunity to do so.

The Seventy-First Charter Anniversary: University of California.—Seventy-one years ago, under the stimulus of the Morrill Land Grant Act, and influenced by the counsel of the trustees of the earlier-established College of California, the Legislature of this State chartered the University of California to provide higher education for the sons and daughters of a pioneer community.

With each passing decade the State of California grew larger and its educational needs more complex, and the University, reflecting that development, has become one of the major institutions of its kind in the world. Through gifts to the state and appropriations from the Legislature, its oldest campus at Berkeley has steadily expanded its offering to meet the needs of twentieth century civilization; and many additional centers have been established to serve special fields of knowledge and new population areas.

On Mount Hamilton there was created an Astronomical Department and Lick Observatory. At San Francisco the Medical Center, comprising the Medical School, College of Dentistry, College of Pharmacy, and Training School for Nurses, has steadily developed. At Davis there has been provided a College of Agriculture and University Farm. At Riverside a Citrus Experiment Station was established. Finally, and most important of all, in 1919 there was created a second general campus of the University which has grown to be the University of California at Los Angeles, thirteenth largest campus in America in its own right.

Supplementing the services offered by these seven major centers are certain affiliated institutions, Hastings College of the Law, and the California School of Fine Arts; a number of research stations; and the University Extension Division and the Agricultural Extension Service which carry the offerings of the University to every county in the state.

For this Seventy-first Charter Anniversary, which falls, also, in the twentieth anniversary year of the University of California at Los Angeles, these various campuses and stations join in a series of commemorative programs for the benefit of the citizens of the state.

Lane Medical Lectures.—The twenty-seventh course of Lane Medical Lectures will be delivered by Thomas M. Rivers, M.D., Sc.D., Director, Hospital of The Rockefeller Institute for Medical Research, on the evenings of May 22, 23, 24, 25, and 26, 1939, at 8:15 o'clock in Lane Hall, Stanford University School of Medicine, Sacramento Street, near Webster, San Francisco. The medical profession, students, teachers, and research workers in medicine and allied sciences are cordially invited to attend.

The Lane Medical Lectures were founded in 1896 by the late Dr. Levi Cooper Lane, and have been given as follows:

1896. Surgery of the Brain.—Sir William Macewen, M.D., Regius Professor of Surgery, University of Glasgow.

1897. Congenital Malformations, Aneurysm, and Other Surgical Topics.—Christopher Heath, F.R.C.S., England, Professor of Clinical Surgery, University College, London.

1898. Diseases of the Heart.—Sir Thomas Clifford Allbutt, M.D., F.R.S., Regius Professor of Physics, University of Cambridge, England.

1899. Topics in General Surgery.—Nicholas Senn, M.D., Ph.D., LL.D., Professor of Surgery, Rush Medical College.

1900. History of Physiology.—Sir Michael Foster, K.C.B., D.C.L., Professor of Physiology, University of Cambridge, England.

1901. Social Aspects of Dermatology.—Sir Malcolm Morris, F.R.C.S., Edinburgh, M.R.C.S., England, Surgeon, Skin Department, St. Mary's Hospital, London.

1902. Diseases of the Rectum.—Sir Charles B. Ball. M.Ch., F.R.C.S., Ireland, Regius Professor of Surgery, University of Dublin.

1903. Dislocations and Fractures Involving Larger Joints. —Oscar H. Allis, M.D., Philadelphia, Pennsylvania.

1904. Infection and Immunity.—William H. Welch, M.D., LL.D., Professor of Pathology, Johns Hopkins University, Baltimore.

1905. Tropical Diseases.—Sir Patrick Manson, K.C.M.G., F.R.S., School of Tropical Medicine, London.

1906. Practical Hygiene, Epidemics, and Preventive Medicine.—John C. McVail, M.D., D.P.H., Cambridge, Glasgow.

1910. A Consideration of Some Features of the Lymphatic System.—Reginald Heber Fitz, M.D., LL.D., Hersey Professor of Theory and Practice of Medicine, Harvard University, Boston, Massachusetts.

1911. The Importance of Ophthalmology in Its Relation to Systemic Diseases.—Ernest Fuchs, Professor of Ophthalmology in the University of Vienna.

1913. Internal Secretion.—Sir Edward A. Schafer, LL.D., Sc.D., M.D., M.R.C.S., F.R.S., Professor of Physiology in the University of Edinburgh.

1915. Focal Infection.—Frank Billings, M. S., M. D., Professor of Medicine in the Rush Medical College, Chicago, Illinois.

1917. Physical Basis and Present Status of Specific Serum and Drug Therapy.—Simon Flexner, M. D., LL. D., Director of Laboratories, Rockefeller Institute for Medical Research, New York City.

1919. The Feeding of the Nations at War.—Alonzo Englebert Taylor, Professor of Physiological Chemistry, University of Pennsylvania, Philadelphia.

1921. Growth and Nutrition.—L. Emmett Holt, M.D., ScD., LL.D., Emeritus Professor of Pediatrics, College of Physicians and Surgeons, Columbia University, New York City.

1924. Selected Topics in Pathology.—Ludwig Aschoff, M.D., Professor of Pathology, University of Freiburg, Germany.

1925. Selected Topics in Orthopedic Surgery,—Vittorio Putti, M.D., Professor of Orthopedic Surgery, University of Bologna, Director Rizzoli Institute of Bologna, Italy.

1928. Bacteriophagy.—F. d'Herelle, M.D., Professor of Bacteriology, Yale University, New Haven, Connecticut.

1929. Selected Topics in Pharmacology.—Walther Straub, M.D., Ph.D., Professor of Pharmacology, University of Munich, Munich, Germany.

1930. Constitution.—Charles R. Stockard, M. D., Ph. D., Sc.D., Professor of Anatomy, Cornell University Medical School, New York City.

1933. Biochemical Studies of Nutritional Problems.—J. C. Drummond, Sc.D., Professor of Biochemistry, University College, University of London, London, England.

1935. Regulation of the Cardiovascular System.—G. V. Anrap, M. D., Sc. D., F. R. S., Professor of Physiology, Egyptian University, Cairo, Egypt.

1937. Mechanism of Heat Loss and Temperature Regulation.—Eugene F. DuBois, M.D., Professor of Medicine, Cornell University Medical College, New York City.

In the 1939 Lane Lectures, Doctor Rivers will give the following:

Lecture I, May 22—Lymphocytic Choriomeningitis.

Lecture II, May 23—Pathology of Virus Disease.

Lecture III, May 24—Immunological and Serological Phenomena of Virus Diseases.

Lecture IV, May 25—Nature of Viruses.

Lecture V, May 26—Treatment and Prevention of Virus Diseases.

Press Clippings.—Some news items from the daily press. on matters related to medical practice, follow:

Fight on Budget Opens*

Sacramento, March 29.—Governor Olson's $557,000,000 state budget for the 1939-1941 biennium became the center of bitter controversy today when the Assembly began debate upon the budget bill. . . .

The budget debate will be resumed tomorrow. One item under fire tonight when the session ended was that for $200,000 for the compulsory health insurance program. Republican Assemblyman Melvin I. Cronin, San Francisco, and his colleagues of the minority party, contend that this item does not belong in the budget bill. They insist that the Legislature should first express itself on the compulsory health insurance question.

"The Ways and Means Committee," declared Cronin, "doesn't know how this item was arrived at and nobody else seems to know it either. This is the opening of a backdoor assent to the passage of a bill not yet before us and probably will need a million dollars if the program is approved. . . .

The minority report was signed by Assemblymen Gerald C. Kepple, Whittier, Charles W. Lyon, Los Angeles, and Clarence R. Walker, Westmoreland.

Without a substantial increase in taxation or a reduction in expenditures it is possible the state will face an estimated general fund deficit as of June 30, 1941, of at least $76,000,000," the minority report declared in urging cuts in the budget.

"The budget presented by the Governor to the Legislature proposed expenditures amounting to $629,272,874, of which $557,163,355 is to be financed through direct state resources, and $72,109,519 is to be financed through Federal grants," they declared.

The minority group outlined various proposed reductions in the budget, including cutting out the $500,000 for a proposed new psychiatric hospital on the property owned by the University of California adjacent to its medical school in San Francisco.

"We believe that departmental expenditures should be checked," the three Republicans reported.—San Francisco *Chronicle,* March 30.

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Olson Budget†

Examiner Bureau, Sacramento, March 29.—Governor Olson's $557,000,000 budget, calling for the largest spending program in the history of California, was given a baptism of fire late today when the Assembly, sitting as a committee of the whole, opened official debate on the supporting appropriation bill.

Republican members of the bipartisan economy bloc led the onslaught on the budget.

One-Man Job

They drew from Democratic Ben Rosenthal, Chairman of the Ways and Means Committee, these significant admissions:

"1. The budget is strictly a one-man document, and Governor Olson is the sole author. He is the only man who holds all the threads, the only man whose advice was heeded by the committee in sending out the bill with a do-pass recommendation.

"2. The committee made no change in the record-high budget asked by the new executive, and for the first time in California's history, sent a budget to the floor of the Assembly without the reduction of so much as one cent.

Study Limited

"3. The committee spent a total of only thirty-three hours in studying the budget—an average of nine minutes for each of the maze of separate items. Many department heads, whose departmental expenditures run high into the millions, never appeared before the committee to justify or explain their budget requests.

"4. With only a few exceptions that could be counted on the fingers of one hand, every department asked and received an increase, some running as high as 494 per cent."

After two hours of debate, Democratic Floor Leader Alfred W. Robertson moved that the discussion be closed until a later date, and the motion was passed. The entire time today was spent in going over the budget, item by item, with Assemblyman Rosenthal and Fred Links, head of the budget division of the Department of Finance, trying to answer legislators' questions. . . .

Typical of the debate today was an interchange between Rosenthal and Assemblyman Melvyn I. Cronin of San Francisco.

Governor Says So

Cronin sought enlightenment on a $200,000 item set up for the initial financing of a compulsory health insurance program—a "must" item on the Administration's docket. A bill providing for such insurance is now pending, but no action has been taken. Cronin wanted to know why the $200,000 was included in the budget.

"The Governor appointed a committee of citizens to conduct a study of this question, and we will hold a hearing on April 20 on the bill," replied Rosenthal.

"But who appeared before your committee in support of the bill and told you $200,000 was needed?" asked Cronin.

"It was explained in the Governor's budget," said Rosenthal. "Isn't that enough? This is the amount he says is needed to get it going. If the bill falls, we can't touch the $200,000."

"I still cannot understand how this money could be set up in the budget under any safe or sane policy," Cronin insisted. "I don't believe you know, or the Governor knows, or anybody else knows, whether $200,000 or any other sum was needed."

Through Back Door

Pinned down for a definite answer, Rosenthal had no explanation other than that "the Governor set the amount down in the budget." Rosenthal admitted he could not say whether any California physician or surgeon had been consulted about the plan.

"This is a back door to legislation of which we may not approve in the final test," Cronin charged.

Prelude to Battle

"I think it ought to be taken out of there, and attached to the compulsory health insurance bill itself if that bill passes. If I understand the opinion of members of the Legislature, the compulsory health insurance bill will not pass."—San Francisco *Examiner,* March 30.

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Attack on Budget Which Brought $200,000 Reduction.*

Sacramento, March 30.—Governor Olson soon will order a shakeup in the State Relief Administration. . . .

This is the word that went the rounds of the Capitol tonight, following a dinner caucus between the Governor and members of his official family and the Democratic majority members of the Assembly.

The dinner, at which those present were pledged to secrecy, was held at the Del Paso Club two hours after the Governor's lieutenants in the Assembly had made their first concession to the Republicans, fighting to reduce the $557,000,000 state budget, by agreeing to lop off a $200,000 health insurance program item from the budget bill.

Stand Is Changed

The Governor previously had notified the Democratic majority he wanted "no change" in the budget. . . .—San Francisco *Chronicle,* March 31.

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Clinic Plans to Be Discussed

Legislation to Check Communicable Diseases Also Will Be Studied Saturday

Plans for the new San Francisco venereal disease clinic will be discussed on Saturday by Lawrence Arnstein, health advisory board, and Dr. George Becker, director of communicable diseases, at a meeting of the Northern California Public Health Association in Sacramento.

Legislative bills requiring physical examinations, including blood tests before marriage, will be discussed by Dr. Nathan C. Hale, Sacramento physician, and Miss Eloise Hafford, executive director of the Southern California Society for the prevention of syphilis and gonorrhea. Public health workers in central and northern counties will also attend the meeting.

Other speakers will be W. F. Higby, secretary, Western States Division, American Social Hygiene Association; Dr. N. N. Ashley, Oakland city health officer; Dr. Philip Condit, state physician; Dr. H. C. Pulley, state physician; and Dr. Malcolm H. Merrill, Chief, Bureau of Venereal Diseases, State Department of Public Health, who will also be chairman of the meeting.—San Francisco *News,* February 23.

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School Named for Doctor Widney

New Structure to Honor Medical Dean

The Board of Education last night gave the name "Dr. Joseph Pomeroy Widney High School" to the Crippled Children's High School, located on the grounds of Polytechnic High School, Twentieth Street and Grand Avenue.

The structure was completed last year at a cost of $100,000.

The late Doctor Widney was the founder of the old College of Medicine of the University of Southern California, was the dean, and later, president of the University. He was also the motivating spirit among the founders of the Los Angeles County Medical Association.—Los Angeles *Times,* March 10.

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* By Earl C. Behrens.

† By R. W. Jimerson.

* By Earl C. Behrens.

Cut Sought in San Francisco's Municipal Health Service Cost

With a view to increasing efficiency and cutting costs of the Municipal Health Service, Cameron King, President of the Board of Directors, today planned to confer with Dr. J. C. Geiger, Director of Public Health.

The meeting was arranged after a conference with Chief City Administrative Officer A. J. Cleary, when King said more space for clerical help was needed and suggested room might be found in the Health Center building.

$18,000 Deficit

King moved to reduce overhead, now running about 14 per cent, when audits of service funds disclosed an $18,000 deficit for January, and a survey of clerical procedure showed low efficiency and much overlapping of duties.

"While I cannot act in an official capacity, I am ready and willing to coöperate with this service. I hope that it will prove a success and I see no reason why it should not succeed," Cleary said.

King announced that the $18,000 deficit will necessitate a cut of about 50 per cent in January payments to physicians.

"Brighter Outlook"

"February outlook is far brighter," King announced. "There will be no increase in deductions from salaries paid by members.

"Summer months will create surpluses and the outlook is that all physicians will eventually receive their full unit payments."—San Francisco *Call-Bulletin*, March 10.

* * *

Doctors Get $20,000 From San Francisco City Health Plan

Checks totaling around $20,000 were mailed out to San Francisco doctors last night by the city employees' Health Service System in payment of January bills.

Because of the prevalence of colds and other ailments in that midwinter month, bills were above revenues from employees' pay deductions and were paid on a 50 per cent basis, it was said.

Under the unit plan agreed to by the 1,100 doctors on the System's panel, administration expenses, hospital and laboratory expenses are paid in full, then the remainder funds may be distributed among the doctors in proportion to the number of units of service given members.

A unit is normally one dollar's worth of service. During the first three months of operation of the System the doctors were recompensed in full, at the rate of $1 per unit. When January bills began coming in, it was recognized that the Board would have to resort to its right to make pro rata payments under the unit plan.

Toward the close of January, Dr. Walter B. Coffey, Medical Director of the System, addressed a letter to all members of the medical staff asking their coöperation in keeping bills down by eliminating unnecessary calls on patients. As a result of that letter and improved health conditions, February bills are expected to be paid at a much higher rate per unit, if not in full.

Shortages in payments to doctors for any month may be made up in succeeding months, according to the plan agreed to by the employees' board and the medical staff. At the end of a year, it was agreed, there could be a review of results to ascertain if there should be any changes in fee schedule for doctors or contributions by members.

Members now pay $2.50 per month for adults, $1.25 for a single minor dependent in a family, $1 each where there are more than one. Except for certain exemptions, membership in the System is compulsory, or a condition of employment, for city employees, voluntary for dependents.

Detailed figures on operations during January are to be released by the Board within a few days. The Board met in special session Thursday to authorize the 50 cents per unit payment of January bills.—San Francisco *Chronicle*, April 1.

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Doctor's Ruling Balks Nazis

Adolf Hitler's political edict last September 30, revoking medical licenses of Jewish doctors in Germany, will not bar emigrant Jewish doctors who began their interneships in California prior to the decree, from obtaining California medical licenses.

Attorney-General Earl Warren made this ruling today in an opinion requested by Dr. Charles B. Pinkham, Secretary of the California Board of Medical Examiners.

"A political edict is no bar," Warren ruled, "if the applicants comply with other requirements."

Doctor Pinkham announced he would seek another ruling from the Attorney-General on doctors who began their interneships after the decree went into effect.—San Francisco *Call-Bulletin*, March 10.

Precaution—Any Method to Curb Dope Traffic Is Good

Pending in the Legislature is a measure which is aimed at making it more difficult for narcotic addicts to obtain dope by forging physician's names to prescriptions.

It is encouraging to learn the number of addicts in the United States has decreased in recent years. This reduction of victims of narcotics is due largely to the enforcement by State and Federal authorities of the laws against the illicit sale and use of drugs, and to the institutions established by the Federal Government and by such states as California to cure addiction.

But the vicious habit must be eradicated entirely.

Since the bill presented by Assemblyman Edward F. O'Day of San Francisco, providing that prescriptions be issued in triplicate, has the support of Paul Madden, Chief of the State Division of Narcotic Enforcement, the State Board of Pharmacy and the California State Medical Association, the Legislature should pass it unanimously.—San Francisco *Examiner*, March 17.

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New Physicians' Service Soon to Be Ready

Doctors Sign Up Rapidly, President Wilbur Reports

Registration of licensed doctors of medicine at the rate of more than 500 a day for the new California Physicians' Service is reported by Dr. Ray Lyman Wilbur, president of the service, which is being organized as a result of action taken recently by the State Medical Association.

This response has advanced the time at which this group prepayment medical, surgical and hospital service can be offered the public, Doctor Wilbur said today. "It exceeds our anticipations," he added, "and we will be able to proceed to the next step, the enrollment of beneficiary, or patient, members very shortly."

The service, which permits wage-earning and other groups to pay small sums monthly, in return for which the members receive care by the doctors and hospitals of their own choice when needed, was launched officially only a week ago, when invitations to become professional members were sent to all doctors of medicine in the state.

Doctor Wilbur points out that the California Physicians' Service is similar to plans successfully operated for several years in Seattle and in Oregon.

Present headquarters are at 220 Montgomery Street, San Francisco, but additional offices will be established in Los Angeles and elsewhere throughout the state.—Palo Alto *Times*, March 13.

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Comments and Cacophony

The medical profession is not getting a square deal from the public. Just when the surgeons and the doctors arrive at the point where they can find out what's the matter with us—and cure it—along comes the politicians and begin their campaign for state medicine, to take the profit out of the profession. When I was a lad, you died of almost anything except chills and fever—and with that, you wished you could die.

Anything inside of you was as much of a mystery to the doctor as the contents of a can of sardines. Doctors could give you a hypodermic to ease the pain and a dose of calomel to "open the bowels"—and then "salivate" you if you happened to eat something containing too much acid—but if you got smallpox, it was luck if you got through, and if you had gall-stones or appendicitis, nobody knew what it was, or, if they did, very few knew what to do about it.

Nowadays, if you have any of these ailments and others too hard to spell, all they do is hold a consultation over you, put you to sleep with an anesthetic if you have a good heart or administer a "local" if the heart's not so good, and relieve you, and you generally get well and if you don't "live happily ever after" you usually live long enough to pay the bill, and your share of taxes.

You are now successfully inoculated or vaccinated against smallpox, diphtheria, scarlet fever and other ills and ailments that used to make life a dreadful lottery and keep humans forever wondering if a new "symptom" was but a prelude to a funeral.

Yellow fever and malaria have been outlawed by getting rid of the mosquitoes, and even the South's "poor white trash" no longer keeps out of work by pleading "chills and fever."

Altogether the doctors have contributed more for the enjoyment of life and to the progress of humanity than any other class of people, and, while they may give a prescription for a little chocolate-colored water occasionally to a chronic complainer, it's because he or she insists on attention and would go somewhere else to get it if not accommodated and charged for it.—Lompoc *Record*, March 10.

County Physicians Vote Medical Plan

New Service Endorsed by Large Group

Ten Thousand Doctors May Help Wage Earners

Without dissent, the Orange County Medical Association at a regular meeting in the chapel of Orange County Hospital, last night, voted to endorse and accept the California Physicians' Service, a plan to provide at the lowest possible cost the benefits of medical, surgical and hospital care to California wage earners.

The plan was endorsed by the California State Medical Association at a special meeting in Los Angeles last December and is the outgrowth of ten years of study by that body.

The plan was launched Monday when more than 10,000 licensed physicians in California received application blanks for membership.

At last night's meeting the county association voiced disapproval of any politically controlled system operated by governmental agencies, in the belief that such a plan would provoke an unusual increase in the tax burden on employees and employers and eventually on the property owner.

Personal choice of physician and possibly of hospital are provisions of the plan which, to facilitate organization, will at first be offered to employed groups, and later to individuals whether employed or not. Industrial accidents already provided for by the industrial commission will be excluded.

The service will be available for approximately $2.50 per month per individual and will be payable to the California Physicians' Service with headquarters at 220 Montgomery Street, San Francisco. The Service is a voluntary, nonprofit corporation.

Allen W. Widenham is general manager of the Service and Dr. Morton R. Gibbons of San Francisco is medical director. The president is Dr. Ray Lyman Wilbur of Stanford University.—Fullerton *News-Tribune,* March 8.

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Doctors Irked by Union Rule

Film Projector Men and Convention Officials in Mixup

St. Louis, March 25 (AP).—If the country's medical men refuse to "play ball" with the unions—and the doctors have their dander up—there may be neither movies nor music at the American Medical Association convention here in May.

Restrictions laid down by the Moving Picture Operators' Union have brought loud protests from professional men who are planning scientific exhibits.

Union Demands

The Association has notified members that motion pictures may not be shown in booths unless the projector is operated by union men at $1.50 an hour in four-hour shifts.

The only way an exhibitor could show his own pictures would be to display them in the general assembly hall, two stories above the exhibit room.

Ordinarily, the doctor who uses a film for demonstration has taken it himself, and shows it himself because he is familiar with the subject matter.

"Insane Condition"

One Medical Association officer declared it is the first time they have run into such a "perfectly insane" condition.

The union has suggested the various noncommercial films be "pooled" and run off together.

"The union is always ready to stretch a point on educational films," said Clyde Weston, business agent.

But this arrangement is not at all satisfactory to the doctors.

Public Benefit

They point out such meetings are exchanges of the latest information ultimately for public benefit, and that more and more scientists are relying on motion pictures to impart complex advances more clearly and accurately than long technical papers.

The Medical Association also has crossed swords with the Musicians' Union, which objects to plans for having a school band and choral group appear before the convention. During the past few months this group has interceded at a number of local functions and refused to let any musicians perform unless union bands were hired.—Los Angeles *Times,* March 26.

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Doctor Brinkley Tells Income Loss in Suit

Del Rio, Texas, March 24 (AP).—Dr. John R. Brinkley testified today in his $250,000 libel suit against Dr. Morris Fishbein that his gross income dropped from around $1,100,000 in 1937 to about $810,000 in 1938 after publication of an article in the American Medical Association's journal, of which Doctor Fishbein is editor.

The specialist, who testified he performed about 5,000 goat-gland operations before he abandoned the use of animal glands in his sex rejuvenation medical treatments in 1933, was called as the first witness by the defense.

The bearded doctor began his testimony after a motion by Doctor Fishbein's attorneys to dismiss the case on a technicality was overruled by Federal Judge R. L. McMillan.

On direct testimony, Dr. Brinkley testified: "As far as I know, I am the man who originated the goat-gland operation." He said he performed the first operation at Milford, Kansas, in 1917.

He said before he began to advertise his operations recommending the implantation of goat, sheep, and monkey glands in impotent men, he was a member of the American Medical Association.

Subsequently he built a hospital at Del Rio, Texas, and moved from Kansas. He now operates two hospitals at Little Rock, Arkansas.

He said he formerly took the glands of three weeks old goats and implanted them in men, but since 1933 a commercial glandular preparation had been placed on the market and that he purchased it now.—Los Angeles *Evening Herald and Express,* March 24.

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Doctors Rap Health Bills

Proposals by State Called Socialistic at Association Meeting

Vigorous opposition to compulsory health insurance bills pending in the California Legislature which they hold will introduce a socialistic and European health system was voiced last night by speakers before an emergency meeting of the Los Angeles County Medical Association.

The meeting, called by the Association Council, headed by Dr. Ralph B. Eusden, was held in Polytechnic High School auditorium and brought out a record attendance of two thousand medical leaders.

Rising Vote

In a rising vote, called for by Dr. Lowell Goin, Speaker of the House of Delegates of the California Medical Association, an estimated two thousand physicians and surgeons registered their disapproval of the two pending measures.

The bills under fire are Senate Bill No. 1127 and Assembly Bill No. 2172. Dr. Samuel Ayers, Jr., who attacked the asserted bureaucratic powers which would be placed in the hands of laymen under the compulsory plan, said:

"Compulsory medicine, as provided in these bills, would result in perfunctory, unscientific, slap-dash services rendered by harried and underpaid doctors in crowded offices.

Unhappy Picture

"Increased taxes and the political spoils system would complete the unhappy picture.

"State control of medicine would be only the forerunner of state control of dentistry, then law, then the press, and, finally, labor. Then the picture of totalitarianism is complete.

"These bills are in no sense progressive legislation and have no place in the program of a progressive administration. It is unadulterated racketeering at the expense of an honest profession."

Steps Already Taken

Allen W. Widenham, general manager of the California Physicians' Service, said that organized medicine already has taken steps to provide adequate medical care in California.

He referred to the medical service sponsored last December by the California Medical Association, which is a voluntary health prepayment plan.

Dr. William H. Daniel, president of the Los Angeles County Medical Association, declaring the proposed legislation "vicious," said it would force on California an inferior grade of medicine, as has been the experience in Europe.

Interference Scored

He said:

"We, as an organized body of medical men, demand that we be allowed to continue the practice of medicine as it has been done, without any third party coming in between doctors and patients."—Los Angeles *Times,* March 24.

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Governor's Committee of Twenty-One

Sacramento, March 23 (AP).—Governor Olson today announced that C. J. Haggerty, State President of the A. F. L., and Phillip M. Connolly, State President of the C. I. O., have accepted places on his committee to study compulsory health insurance proposals.—Los Angeles *Times,* March 24.

Five Hundred Doctors Daily Joining California Physicians' Service

Prepayment Plan to Be Offered to Public Soon

Registration of licensed doctors in the newly formed California Physicians' Service is proceeding at the rate of more than five hundred per day, and the new "group prepayment medical, surgical and hospital service" will soon be offered to the public.

Dr. Ray Lyman Wilbur, President of the Service, made this announcement yesterday. The Service will permit wage-earners and other groups to pay small sums monthly in return for care by doctors and hospitals of their own choice when needed.

"The Service was launched only a week ago, when all doctors of medicine in the state were invited to become professional members," Doctor Wilbur said. "The response has been so enthusiastic we will be able to complete our organization sooner than expected and will soon proceed to the next step, the enrollment of beneficiary or patient members."—San Francisco *Examiner,* March 14.

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Nursing Bill Approved by Assembly Unit

Heated Debate Marks Capitol Hearing on Plan to Set Up State Board of Examiners

Examiner Bureau, Sacramento, March 17.—A bill to establish a state board of nurse examiners was recommended favorably today by an Assembly committee on medical and dental laws after a hearing marked by frequent clashes between opposing interests.

Acrimonious debate on the measure at times reached a pitch which brought hoots and boos from the hearing crowd, which included representatives of 27,000 registered nurses, favoring the proposal, and practical nurses, opposing it.

Spokesmen for chiropractors joined the practical nurses in fighting the bill, introduced by Assemblyman Melvyn I. Cronin of San Francisco.

State Nurses Approve

Support of the bill was led by Mrs. J. W. Gardner of Davis, representing the California State Nurses' Association. She explained the measure would create a board of five members under the jurisdiction of the State Department of Professional and Vocational Standards. All the members would be licensed nurses, and would be appointed by the Governor. Wide powers would be given the board to regulate the nursing profession, grant licenses to nurses, and accredit approved schools of nursing.

She declared that the prevalence of "correspondence school nurses, laxity in the present California law, numerous abuses in the name of the profession, and widespread exploitation of the public" make the bill necessary.

Stormy Session

At times, nurses who packed the hearing broke into demonstrations which forced Chairman Hugh M. Burns of Fresno to rap loudly for order.

Principal opponent of the bill was Maxine Alberts, president of the American Trained Association of Nurses, who declared the measure would "discriminate unfairly against trained practical nurses."

Dr. Junius B. Harris of Sacramento, head of the California Medical Association's legislative committee, presented seven suggested amendments to the bill. He accused the registered nurses of attempting to "tear down the whole edifice of nursing by trying to raise the standards of the profession too high, to a point where the average person would be unable to afford a nurse."

J. Vernon Burke of Labor's Non-Partisan League appeared to defend the bill, while Dr. W. Franklin Morris, representing the National Affiliated Chiropractors, declared it would throw hundreds of girl office attendants in chiropractors' offices out of work.—San Francisco *Examiner,* March 18.

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Health Service

Editor:—A few days ago there appeared in The San Francisco *News* a report of an interview with the undersigned on the subject of health insurance.

The interview opened with the declaration that the speaker was in favor of the supply of medical service to those of moderate means, no matter what form of financing was used. Through no fault of the interviewer, the meanings of these sentences were insufficiently expanded and clarified. The statement was intended to imply that any law covering the subject of so-called health insurance might advantageously provide for several forms of insurance financing. For instance: (1) A compulsory system financed on a capitation plan; (2) a voluntary system such as that proposed by the California Medical Association, financed on a fee system, or if it was preferred by the sponsors, on a capitation system; (3) an insurance carrier system financed to provide cash indemnity and nothing else, and there are others which might advantageously be considered before the legislation is finally passed.

In a free economy, such as ours, no harm can come from a democratic inclusion of various ideas. Unquestionably, as has happened in England, the more practical plans in time will dominate to the exclusion of others.

The writer makes no claim to authority in this field; his only excuse for writing is an interest which has lasted for twenty-five years. His opinions are merely opinions. However, he is convinced that nothing could be more damaging to the public health than legislation which would impair the financial independence and the social authority of practicing physicians.—Langley Porter, M. D.—San Francisco *News,* March 6.

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New Bill to Curb Dope Sale Fraud

Wholesale Forgery of Prescriptions Revealed

Examiner Bureau, Sacramento, March 14.—Strong legislative safeguards were in process of preparation tonight following disclosures of wholesale forgeries of physicians' narcotics prescriptions.

Paul Madden, Chief of the State Division of Narcotics Enforcement, and Assemblyman Edward F. O'Day of San Francisco, serving his first term in the Legislature, took the lead in the legislative campaign to cut off this virtually uncontrolled source of supply to dope addicts.

Madden, appointed as successor to William G. Walker a month ago, said his investigations turned up "a situation where a tremendous amount of forged prescriptions on legitimate doctors were being passed to legitimate pharmacies."

"It is serious enough to demand immediate attention and legislative action," he explained.

Although the investigation is barely under way, Madden said one of a Los Angeles chain of pharmacies was discovered to have filled fifteen forged prescriptions. Both Madden and the Federal Narcotics Bureau have sent operatives to Los Angeles to continue the investigation.

"Heretofore, narcotics were issued by pharmacists on the strength of ordinary physicians' prescriptions," Madden explained. "It was comparatively simple for addicts to steal a pad of prescription blanks and obtain drugs almost at will.

"We have even found cases where the addict was having his own prescription blanks printed."

The measure O'Day will submit to the Legislature within a few days will provide for issuance of numbered prescription blanks by Madden's office. The blanks will be in triplicate form. One will be kept in the book by the issuing doctor and two will be turned over by the purchaser to the pharmacist, who will send one of the copies to the division, Madden said.

"This way, both the pharmacist and the physician will be given protection and the addict will be cut off," he said.

Madden said O'Day's bill will carry the unanimous backing of the State Board of Pharmacy and the Medical Association.

It will probably provide a misdemeanor penalty, with physicians or pharmacists subject to license revocation for violation of the law.—Los Angeles *Examiner,* March 15.

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Doctors Hold One Hundredth Session

Strides in Southland Medicine Discussed

For the one hundredth time in fifty years, the Southern California Medical Association convened yesterday to discuss advances that Southland medicine has made in the past six months.

The Los Angeles County Medical Association's headquarters at 1925 Wilshire Boulevard, was the site chosen for this semicentennial celebration of the doctors. The two-day session will close tonight at 8 o'clock with a joint meeting of the Southland and county medical groups.—Los Angeles *Times,* March 16.

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American Medical Association Head Denies Medical Monopoly

Five hundred physicians and surgeons returned to their Southland homes today after hearing a stinging indictment of the government's proposals for compulsory health insurance and socialized medicine delivered by Dr. Rock Sleyster at the concluding session of the joint semi-annual conference of the Los Angeles County and Southern California Medical Associations.

Doctor Sleyster of Wauwatosa, Wisconsin, is President-elect of the American Medical Association. Emphatically he denied that the American Medical Association is seeking to maintain a medical monopoly and charged that the Government's move toward compulsory health insurance and socialized medicine was prompted by propagandists.

"Proponents are trying to create the impression that one-third of our population is without medical care and that through this breakdown there exists an emergency requiring further centralization at Washington," Doctor Sleyster declared.

"Reports of the United States Public Health Service and life insurance companies show the absurdity of these unsupported claims, appealing to the emotions and intended as a build-up for the adoption of European schemes which have all but wrecked medicine abroad."

The speaker denied that the medical profession is opposing plans to provide prepayment for medical care.

"Nothing could be farther from the truth," he declared. "More than three hundred different plans are now being tried out in this country with the full approval of the medical profession."

Concluding sectional meetings at the joint conference, held at 1925 Wilshire Boulevard, were devoted to the uses and dangers of the new drug, sulfanilamide. Papers on the topic were submitted by Dr. A. G. Bower, Chief of the Communicable Disease Division at Los Angeles General Hospital, and his associate, Dr. William J. Mitchell, Jr.—Los Angeles *Evening Herald and Express,* March 17.

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United States Health Program Flayed

American Medical Association Leader Calls Plans Communistic

In case anybody thought the American Medical Association had bowed before the inevitable and was now ready to accept a nation-wide program of compulsory health insurance, he should have another think today.

For Dr. Rock Sleyster, President-elect of the American Medical Association, appeared before a Los Angeles medical audience last night and rang the same old tocsin.

Washington's plans for providing medical care to "one-third of a nation" which is not only ill clothed, ill housed and ill fed but also ill doctored or not doctored at all, are, in Doctor Sleyster's opinion, "socialistic and communistic doctrines."

The administration—a "political agency which has failed utterly to bring about prosperity"—is "threatening" to foist upon America "such a European political panacea as has all but wrecked medicine in those countries."

Doctor Sleyster spoke before some five hundred members of the Los Angeles County Medical Association and California Medical Association.

He told them that there was no breakdown of medical service in the United States, that there was no need for compulsory health insurance, that "absurd and unsupported claims, appealing to the emotions, are being used as a buildup for further centralization in Washington."

He said United States public health service records and life insurance records would show for 1938 the lowest mortality and lowest incidence of illness for the United States of any country at any time in history. "The medical profession is not, however, necessarily opposed to prepayment plans for medical care," he added . "More than three hundred different plans are being tried out with full approval of the medical profession.

"We do oppose plans which take away from the patient his American right to a free choice of physician. We oppose plans which will tend to create commercial groups each offering a little more for a little less—for this can only lead to an inferior quality of medical service—and cheap service is expensive service."

Dr. John C. Ruddock, President of the Southern California Medical Association, presided over last night's meeting. During the morning and afternoon sessions eight doctors read papers on recent advancements in medical science.—Los Angeles *Evening News,* March 17.

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Leading Biologists to Meet at Stanford

Stanford University, March 19.—Four leading European biologists, including a Nobel prize winner, will participate in a conference marking the centennial of the cell theory here, starting June 5, it was announced today.

They are A. von Szent-Gyorgyi of Szeged, Hungary, awarded the Nobel prize in 1937 for having isolated vitamin C; Hugo Theorell of Stockholm, Sweden, noted for his work on the molecular structure of enzymes; J. D. Bernal of the University of London, England's greatest authority on the study of vitamins, viruses and proteins by x-ray methods, and A. J. Kluyver of Delft, Holland, prominent for revolutionizing scientific ideas about the role of oxygen in microorganisms.—San Francisco *Chronicle,* March 20.

Health Conference

Dr. W. M. Dickie to Attend Meeting in Washington

Dr. W. M. Dickie, State Director of Public Health, will leave San Francisco next month to attend a conference in Washington called by Miss Katherine F. Lenroot, Chief, United States Children's Bureau, and Dr. Thomas Parran, United States Surgeon-General.

The conference, called to devise a national program for the extension of medical and health services, will be held April 20 to 25. Subjects for discussion will include proposed broadening of public health services, the merit system for public health employees, nutrition and diet deficiencies and the crippled children services of the Social Security Act.—San Francisco *News,* March 13.

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Pediatricians From Nine States to Attend Sessions in Oakland

Pediatricians from nine western states, Hawaii, Alberta and British Columbia will convene at Hotel Leamington, Oakland, April 6-8 for the annual meeting of Region VI of the American Academy of Pediatrics.

The academy, comprised of 1,257 child specialists in the United States, Canada and Hawaii, was founded in 1929.

An important aspect of the work of the doctor members is to coördinate child health services in each state and to act in an advisory capacity to Government agencies dealing with child welfare.

Chairmen of the local committees arranging for the meeting are Dr. Clifford Sweet, Oakland; Dr. Clarence B. Hills, Berkeley; Mrs. Lawrence R. Jacobus, Oakland; Dr. Robert S. Leet, Oakland; Dr. Henry E. Stafford, Oakland; Dr. A. L. Gleason, Oakland; Dr. Hubert E. Long, Berkeley, and Dr. Edith M. Meyers, Oakland.

School Principals to Meet Here

The state convention of the Association of California Secondary School Principals will be held here, April 3, 4 and 5, according to Harry G. Hansell, Secretary.

The meeting will be concurrent with the state conference of elementary school superintendents and principals in Oakland.—San Francisco *Chronicle,* March 20.

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Roosevelt to Receive Report on Problem of California's Migrants

Representatives' Committee Declares Housing, Health, Education of Dust Bowl Refugees Transcends State Lines

A statement that the burden of caring for nearly a half-million migratory farm workers in California should be placed in Federal hands will be laid before President Roosevelt within the next few days, advices from Washington revealed today.

The report, prepared by a committee of California representatives for a subcommittee named by Mr. Roosevelt, declared the problems of housing, health and education of migrants transcends state lines and is of great importance to the nation at large.

The California members of the House gave unanimous approval. The report was released locally through the Farm Security Administration of the Department of Agriculture.

The report stresses the committee's belief that California should not be required to sacrifice its present high standards of wages, relief or old-age pensions by assuming more than its share in what is basically a great national problem.

Ready to Do Share

California stands ready to do its share, but despite the excellent work done by the Farm Security Administration and other agencies, the Federal Government has not yet assumed its fair share of the burden, the report declared.

A seven-point program arrived at by the special committee under the chairmanship of Representative Alfred J. Elliott, aided by Representatives Jerry Voorhis and Thomas F. Ford, has been passed on to a subcommittee appointed by President Roosevelt.

The presidential group includes Dr. Thomas Parran, United States Public Health Service; Dr. Will W. Alexander, Administrator of the Farm Security Administration; Arthur J. Altmeyer, Social Security Board, and A. D. Hollenbeck, United States Employment Service. W. P. Lawson, WPA Administrator for Northern California, will serve as an ex-officio member of the committee, which in turn is expected to submit further recommendations for the solution of the migratory labor problem.

The department heads have the report ready for submission to Mr. Roosevelt. It was whipped into shape at a meeting in Colonel Harrington's office Monday.

Rumors have been heard that the report will recommend additional WPA funds for California to put ten thousand more residents on rolls, in exchange for which the state would be asked to aid migrants. An alternative proposal was for legislation providing that unemployed persons anywhere in the Southwest might be employable on any projects there.

Number Increasing

Despite the marked decline in the number of families of dust bowl refugees that have poured into California's great central valleys seeking agricultural employment during the past few years, the report reveals that "we probably have in the neighborhood of 150,000 to 250,000 floating families in our state who will remain there from now on. We also know, that in spite of anything that can be done, more people will come in the future."

In the San Joaquin Valley alone, the report estimates, that there are probably 25,000 people living in tents, old boxes, and every sort of improvised structures.

To meet the problems that the migratory workers have created, the report suggests an expansion of the Farm Placement Service so that migratory agricultural workers could be constantly in touch with employment opportunities and that they might be warned where there is an oversupply of farm labor in the fields.

FSA Expansion Urged

The expansion of the FSA program of settling people on small plots of land in regions where seasonable labor is available should also be furthered, the report recommends.

Health conditions were found to be "deplorable" among the migratory workers as studies during the past year revealed that there were 18,000 cases of undernourishment among the migrant children.

The steadily increasing load on local and county hospitals could be curtailed, the report suggested, through the expansion of the Agricultural Workers Health and Medical Association and further grants from the FSA, its parent organization.

The report likewise suggested that the establishment of clinics and emergency hospitals at the existing Federal camps for migrant workers would take a load from the shoulders of the small-town doctors and hospitals.

As a means of bringing immediate aid to undernourished migrant children, the report suggests that the Surplus Commodities Corporation furnish a balanced ration of foodstuffs to the State Relief Administration or to the FSA for distribution to the needy.

The combination of the FSA program for building camps for the migratory workers and the increased housing facilities supplied by the farmers has done much to help solve the housing problem of migrant workers, the report acknowledges, but it points out that the Federal camps should not only be built in California but in all sections of the nation where migratory agricultural labor is an important factor.

Admitting that the problem of educating the growing children of the wandering migratory workers is one of the most vexing and complicated ones that faces the authorities, the committee suggests a Federal bill to aid the children be passed.—San Francisco *News*, March 7.

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Free Venereal Service Given 52,040 Monthly

California Second to Massachusetts in Providing Treatment

Medically indigent patients were given an average of 52,040 treatments for venereal disease each month during 1938 in California clinics and state institutions as part of the State Department of Public Health's venereal disease control program, department statistics showed today.

This placed California second among all the states in providing treatment for venereal disease patients who are unable to pay the cost of medical care. Massachusetts was listed as first by the United States Public Health Service in the number of clinic treatments, with a monthly average of 79,170, while New York came third with 51,746.

San Francisco Second to Los Angeles

In San Francisco, 125,124 clinic treatments were given last year. San Francisco was second only to Los Angeles, of California cities. Los Angeles gave 245,935.

In addition to the 624,450 treatments given last year in the clinics of California, Dr. W. M. Dickie, state health director, estimated that private physicians gave patients 1,580,000 treatments for syphilis and gonorrhea.

Free Drugs Given Doctors

Doctor Dickie pointed out that the State Department of Public Health distributes free antisyphilitic drugs to private physicians for the treatment of patients who are able to pay only part of the cost and for those who do not live near clinics.

At 680 Howard Street the San Francisco Health Departmen clinic for the diagnosis, treatment and prevention of syphilis was opened yesterday.—San Francisco *News*, March 7.

State Secretary Talks to Medics

Approval of California Physicians' Service Is Expressed in Talk

The background of organized medicine was described last night by Dr. George Kress of San Francisco, Secretary of the California State Medical Association, before thirty members of the Stanislaus County Medical Association meeting in Hotel Hughson.

Doctor Kress expressed himself highly in favor of the California Physicians' Service, a new voluntary health insurance program.

Quotes English Authority

The speaker quoted an English authority who said, following an extensive visit to this country, that socialized medicine could not work here because of the contrast in conditions in this country as compared with England and other parts of Europe.

Dr. A. E. Anderson of Fresno spoke briefly about the new medical program and outlined a county hospital bill, which is to come up before the State Legislature.

Will Form Auxiliary

During the business meeting it was decided by the members to organize a Woman's Auxiliary to the County Medical Association. An organization meeting will be held between now and May 1 so as to enable delegates from the auxiliary to attend the annual convention at Del Monte.

An Advisory Committee was appointed to supervise the organization of the Auxiliary, including Dr. R. Stewart Hiatt, Dr. E. R. McPheeters, Dr. Ernest G. Allen of Patterson, Dr. Marion Collins of Turlock, and Dr. Hoyt R. Gant of Modesto. Mrs. Gant was appointed to handle organization details. Modesto *Bee* and *News Herald*, March 11.

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Flea Laboratory Baffles Plague

San Francisco Scientific Center, With Tests Given Rodents

On the hillside back of the University of California Hospital yesterday was opened, completely without ceremony, a little concrete building which might be called a monument to the flea.

It's a pretty grim monument, however, for of all the thousands of fleas already dwelling in it, and of all the hundreds of thousands which will enter it later, not one will emerge alive.

The building is dedicated to the halting of the sylvatic plague.

War on Disease

The sylvatic plague is a blood cousin to the bubonic plague, the dread "black plague," which one time spread a blanket of death over a huge portion of the civilized world, and even after the turn of this century, claimed literally millions of lives in the Orient.

The bubonic plague, modern science has learned, was spread by the flea, carried by rats. The sylvatic plague, too, is spread by fleas. In America, cases of infection have been rare, but the percentage of mortality after infection is perilously high.

But to bulwark against the day when the plague might rise up and strike down thousands, and to cut down the chances of that occurrence to the lowest possible fraction, medical science is making elaborate preparations.

Scientific Research

With the opening of the Hooper Foundation's "flea laboratory," made possible by a $24,000 gift of the Rosenberg Foundation for research. San Francisco yesterday became the scientific center of the world in point of sylvatic plague lore.

Within the two-story concrete building are dozens on dozens of cages, containing every form of rodent from every spot in Western United States where plague has been found among the animals.

From the fur of these animals the fleas are industriously combed, deposited in covered jars and buckets, and allowed to live freely until their day of doom arrives.

Serum Made

On that day, the ill-fated flea is pulled from his habitat by a suction pump, killed and placed on a slide under a microscope. There, scientists skilled in the ways and looks of fleas can tell at a glance whether their subject be a human flea, dog-and-cat flea, squirrel flea or guinea pig flea.

Then this flea, with a crew of his luckless cronies, is mashed up and cooked into a serum, which is injected into a guinea pig. If the guinea pig comes down with the plague, it is a scientific triumph, for the experimentor, by consulting his case history, can tell what animal carried the flea, and where he came from.

This procedure, now in its infancy as applied to fleas and their "host" animals, will go forward swiftly in this new ultra-modern laboratory. The result will be that very shortly, the Hooper Foundation scientists will be able to draw an accurate map of plague occurrence in the United States, point out precisely what agencies carry the disease, and take direct steps to eradicate the carriers.

And meanwhile, the flea is being given a degree of attention he never received before, in his escape-proof prison of which even the windows are double and rubber-sealed.

All Sterilized

What happens if a plague-bearing flea gets loose in the laboratory? He hasn't a chance. Everybody that comes out of the laboratory must strip, bathe, and put his clothing through a sterilizer. The floors and walls are gleaming white, to enable detection of any stray bug. And in event of real danger, the whole place can be shut off and poisonous vapor injected through vents in the heavy doors.

In this little scientific wonderhouse, almost any day from now on, you'll be able to find Dr. K. F. Meyer, head of the Hooper Foundation; Dr. Charles M. Wheeler, entomologist; Professor Maurice A. Stewart of the Agriculture School at Davis, and a couple of other specialists, all plotting the demise of the plague-bearing flea.—San Francisco *Examiner*, March 22.

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Mistakes in Social Security Law Told

With many groups clamoring for "freezing" or lowering of Social Security pay-roll taxes, the House Ways and Means Committee is now hearing testimony of experts in preparation for a decision on this issue, and expansion of the law. Future cost of the old-age annuity plan is one of the major problems being studied.

Washington, March 21.—Disclosure that serious errors were made by experts advising Congress when the far-flung Social Security Act was enacted, today raised pending revision of the law to the status of a major congressional issue.

While friends of the system declared that, even if errors were made in charting the future cost of the plan, it still is sound, its critics called for a complete reëxamination of the entire system.

The House Ways and Means Committee, following recent testimony of Dr. E. E. Witte of Wisconsin University, chief administration witness when the law was enacted in 1935, planned further investigation into future costs of the old-age annuity plan which affects more than 30,000,000 people.

Foresee General Levy

When the old-age annuity plan was adopted, with both worker and employer paying pay-roll taxes to build up a reserve fund out of which to pay pensions to those over 65, it was estimated that the plan would be self-sustaining for at least thirty years.

Payroll taxes, beginning at 1 per cent each and rising to 3 per cent each in 1949, were levied to finance the system. The basis of the actuaries, according to Doctor Witte, is now shown to be in error.

A general levy of government taxes to help support the system, it is now estimated, may come much earlier than was expected. Eventual cost of old-age pensions is expected to equal a pay-roll tax of 10 to 13 per cent.

Errors of Experts Listed

Errors of actuarial experts listed by Doctor Witte, executive director of the Committee for Economic Security, which recommended the Social Security Act, included:

1. Whereas actuaries estimated 6,000,000 would draw benefits in 1980, new estimates indicate that 13,000,000 will be eligible for pensions.
2. The national birthrate is declining much more rapidly than was shown in figures on which experts based estimates. This means greater proportion of old people in the future.
3. People will live longer than the figures of from 10 to 15 years ago indicated for the future.
4. Old-age annuity pay-roll taxes were based upon an average wage of $1,100 a year. In 1937 the average was only $867.
5. Error was made in calculating the number of persons in exempted occupations who would work part of time in covered occupations, and thus become eligible for benefits.

All of these factors, it was explained, mean that the future cost of old-age annuities will be far greater than was anticipated.

May Have to Levy Taxes

The result is that, unless pay-roll taxes are increased, the government may be confronted in the future with the necessity of levying taxes to support the aged, which will either cause collapse of the system or interfere with the credit of the government.

The situation was cited by various congressional groups to push their own plans of revising the Social Security Act. Administration leaders declared that testimony of Doctor Witte, who vigorously defended the Social Security Act, shows the necessity of keeping the present pay-roll taxes and letting the future increases go into effect. They insist that it wipes out the Republicans' claim that the huge reserve fund being built up in the early years of the law is unnecessary.

Rep. Jenkins, Republican of Ohio, a member of the Ways and Means Committee, declared that the disclosure shows "the fallacy of the present plan and that Congress must adopt a pay-as-you-go policy." — Los Angeles *Evening Herald and Express*, March 21.

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"Man on Street" May Get Aid When Sick Under New Health Bill

Washington, March 21 (AP).—The man on the street, who seldom thinks about his health until he gets sick, may find the state and federal governments looking out for his interests if Congress approves a bill of Senator Wagner, Democrat of New York.

Wagner's measure, introduced after President Roosevelt advocated study of the nation's health needs, would authorize an appropriation of $92,000,000 next year for grants to states. The states would be required to match the federal funds on a ratio varying with their financial resources.

Senator Wagner explained today that it would be up to the states to decide who would get medical and hospital care and how much—whether such aid should be limited to the indigent or whether all could share in it on a contributing basis.

Draft Own Rules

Under the broad terms of his bill, states must comply with certain regulations to obtain federal aid. Beyond that, however, they could draft their own rules.

If a state wished to institute a health insurance program, under which workers could contribute a specified amount each week toward the cost of obtaining medical or hospital care when they need it, the state would be at liberty to do so.

If, on the other hand, the state desired to extend such aid only to the poor, it would have that right.

The bill would broaden the program of maternal and child health functions now carried on under the Social Security Act. It would supplement existing appropriations for the medical care of crippled children.

Enlarge Health Service

Public health services would be enlarged, especially in rural and slum areas. States would receive grants to expand hospitals and health centers. Funds for state payments of disability compensation would be authorized.

In effect, Wagner explained, this would call for establishment of "sickness insurance," by which a worker could obtain funds to defray medical and hospital costs while he was ill.

The method of establishing such insurance, like other proposals in the bill, would be left largely to the discretion of the states.

Delay Consideration

Wagner said that under no circumstances would the federal government "go into the business of furnishing medical care or interfere with the states in the licensing of medical or other practitioners."

The American Medical Association has approved the broad objectives of the health report which Roosevelt submitted to Congress, but has criticized some of the details.

Congress has shown no disposition to act quickly on the Wagner bill, and in some quarters it was believed that consideration might be deferred until next year.—Los Angeles *Evening Herald and Express*, March 21.

* * *

Drive Against Infantile Paralysis Nets $126,504 for Southland

Southern California raised $126,504.97 for the 1939 infantile paralysis drive just ended.

This was revealed by Joseph M. Schenck, general chairman for California, in submitting his report at a luncheon tendered to the advisory committee at the Twentieth Century-Fox studios yesterday.

Contributions for 1939 were 65 per cent above last year's campaign, with Los Angeles County going 79 per cent above last year, the chairman's report showed.

Special praise was given to the campaign conducted in Los Angeles County, for which Sheriff Biscailuz was county chairman, and to Joseph Scott, Southern California chairman. A total of $107,707.68 was raised in this county. Los Angeles County will have as its share to spend during the coming year the sum of $47,974.21, and $56,346.69 will be turned over by the Southern California committee to the National Foundation for Research, Medical Supplies and Reapportionment of Local Relief.

Mr. Schenck also announced that the advisory committee will have complete authority in the administration of infantile paralysis relief funds in this county.

Members of this advisory committee are Norman Chandler, Mrs. James K. Lytle, Victor H. Rossetti, Joseph Scott, Dr. Harlan G. Shoemaker and Bishop Bertrand W. Stevens. F. L. Metzler, treasurer of the fund, also was present at yesterday's luncheon.

The work by drive leaders in other Southern California counties also was lauded, with Mr. Schenck announcing that checks will go forward immediately to the chairmen of the various other Southern California counties for the proportionate share raised in those counties. Aside from Los Angeles County, where the advisory committee administers relief funds, county chairmen will have charge of relief disbursements in their districts, it was stated.—Los Angeles *Times,* March 16.

* * *

Second Jury Disagrees in Chiropractor Case

Whether a chiropractor may attend a woman in childbirth is still a moot point in California jurisprudence.

After deliberating for two days, the second jury trying Dr. David C. Long, a chiropractor, on a charge of violating the Medical Practice Act, reported that it was deadlocked, 6 to 6. The jury was dismissed and Municipal Judge Harold P. Landreth ordered Doctor Long to trial again on April 14.

At the first trial the jury was deadlocked 10 to 2 for acquittal.

The case against Doctor Long is based on delivery of a child to Mrs. Wilton Whitehouse of 1224 West Slauson Avenue.

The city attorney's office contends *delivery of a child constitutes surgery, which chiropractors are forbidden to practice in California.*

Doctor Long contends that such treatment is not surgery and produced numerous chiropractors who testified that they attended women in childbirth and always had considered such treatment within the realm of chiropractors. One chiropractor testified that he had delivered 1,000 children without the death of a child or mother.

The case is attracting much attention among chiropractors because the decision will determine whether or not they are permitted to attend expectant mothers.—Los Angeles *Herald and Express,* March 15.

* * *

American Plan of Federal Aid Needed

The national health program prepared by the Interdepartmental Committee to Coördinate Health and Welfare Activities, and submitted to Congress by the President with a recommendation for "careful study," seems in most part to be soundly conceived.

Its objective, as the President stated it, is "to make available in all parts of our country and for all groups of our people the scientific knowledge and skill at our command to prevent and care for sickness and disability."

To accomplish this, the committee (again in the words of the President) "does not propose a great expansion of Federal health service. It recommends that plans be worked out and administered by states and localities with the assistance of Federal grants-in-aid."

The President correctly foresees that the country, in entire agreement with the objective of the program, would draw back from only one threatened phase of it.

That is the danger of another enormously expensive and enormously inefficient and enormously wasteful and extravagant arm of bureaucracy being attached to the body of government.

Of course, all the people, regardless of means, ought to have the full benefit of the full resources of medical science.

Of course, there ought to be a sufficient number of competent doctors and adequate hospital facilities in every community to maintain public health.

Of course, communities unable to support adequate health facilities must have assistance.

And of course, the Federal Government ought to give such assistance.

Public health is inseparable from public welfare, and the Federal Government can no more be indifferent to inadequate health facilities than it could be negligent in the face of invasion or disaster or any other menace to public safety and security.

But the necessity for a national health program should not be an excuse for setting up new bureaucratic agencies of waste and extravagance, of money-plunder and job-plunder.

It should not be an excuse for starting out on another socialistic or communistic experiment.

Too many Federal experiments have started out with good intentions and objectives, only to turn into socialistic and communistic failures.

Too many of them get out of the hands of people with good intentions and into the hands of people with fantastic theories and selfish purposes.

The national health program has apparently been launched on a sound, helpful American course and should be kept on that course.

The desire of the country is not socialized medicine, but Americanized medicine.

The desire of the country is expansion of health services and facilities, as the President says, "to all groups of our people," not socialistic regimentation of either doctors or the sick.

Through well ordered and well planned Federal grants-in-aid, as the committee suggests, no American community need be without competent health services and adequate health facilities, and no part of our people need be denied their rightful chance for health.

* * *

Reveal 50,646 Age Pensioners in County

According to a report made public today by the California Taxpayers Association, old age aid was extended to 50,646 persons in Los Angeles County last December. In dollars and cents, the aid to the needy aged in the county for that month totaled $1,633,490, which amounted to an average payment per individual of $32.25 for the month, the report stated.

Over California as a whole, old age assistance payments were granted to 125,270 aged persons during December. This, the association stated, represents approximately 27 per cent of the population in the State more than 65 years of age and amounted to a total aid extended for the month of $4,062,915, or an average of $32.43 per person aided.

The cost of old age in California for 1938 will total nearly $50,000,000, the association declared, pointing out that this represents about a tenth of the total cost of State and local government. The cost, according to the Taxpayers Association, for 1938 will be divided $20,607,341 from Federal funds, $20,464,769 from the State, and $8,464,769 from the counties.

Since July, 1930, the number of persons receiving old age assistance in California has increased steadily from 2,542 to the 125,270 aided in December, 1938, the association stated. Average aid per person went from $22.08 for 1930 to $32.33 for 1938, and the cost of the total aid granted went from $641,102 for 1929–1930 to an estimated $49,536,879 for 1938–1939. The causes for these tremendous increases, the association declared, are the liberalizations made in the eligibility requirements and the increases in individual benefits.—Los Angeles *Evening Herald and Express,* February 27.

* * *

Lowest Rate of Sickness Is Cited

Doctors Praised by Dr. Rock Sleyster, President-Elect of American Medical Association

Hits Compulsory Medical Plans

As in grandfather's day, the "family doctor" remains the best consultant for the average man, and his good work has done much to make America the healthiest of all nations, in the opinion of Dr. Rock Sleyster of Wisconsin, President-Elect of the American Medical Association, who is a winter guest at the Huntington Hotel.

Twelve Years of Service

Doctor Sleyster, who lives in Wauwatosa, Milwaukee suburb, is a former president of the Wisconsin Medical Association. He takes office as president of the American Medical Association, whose 120,000 members embrace all branches of medicine, at the Society's St. Louis convention in the spring. He was honored with the presidency of this large organization after serving twelve years as chairman of its Board of Trustees.

A man of lively intellect and great charm of manner, Doctor Sleyster today, in an interview, discussed current views of orthodox medicine and his own viewpoint on moot questions involving the profession.

"We are opposed," he said, "to national socialized medicine or compulsory health insurance and believe that the problems of the cost of medical care for the low-income groups and indigents can best be solved by arrangements in different localities.

He understood, he said, that the California Medical Association had a very good plan.

"Politics" Opposed

Objections to medical service administered by government was that it would develop "political doctors" and that the spirit and initiative of the medical profession would be impaired.

Doctor Sleyster also stated that medical costs often are needlessly excessive, because people demand so much, and that this tendency has helped promote the notion that all medical servic costs too much.

"You know we have become rather spoiled as a people; everybody demands the best, and as much as possible of that," he said. "The best way for the average American family to keep the cost of sickness down is to consult the family doctor. Notwithstanding the rise of specialists, he remains the backbone of the medical profession. He is a good man, a neighbor, and he can tell what should be done. He will not incur extra expense for the family unless it is absolutely necessary."

Help Spread False Idea

Yet there are some people—and a great many of them can afford it—who demand all the tests and treatments modern medical science has evolved; even those who shop around from office to office. These well-to-do hypochondriacs have helped spread the idea that medical service costs too much, he said.

But it was true, said Doctor Sleyster, that use, when necessary, of x-rays and other scientific equipment and hospitalization did make sickness an economic hardship for many families in low-income groups, and for their benefit the medical profession was eager to work out plans whereby costs could be minimized.

Doctor Sleyster was, however, indignant at "propaganda" being disseminated against the medical profession as now constituted by proponents of compulsory health insurance, socialized medicine and kindred plans.

"The charge of propogandists that last year 40,000,000 Americans had to go without medical care because they had no money is utterly ridiculous," said Doctor Sleyster. He was particularly hurt by it not only because the figure was absurd, but because no account was taken of the millions of hours of time and service contributed, free, by doctors in every community, to poor.

Cites Low Death Rate

"The absurdity of such propaganda may be judged," he continued, "by the fact that the statistics of two great health fact-finding bodies, the United States Public Health Service and the Metropolitan Life Insurance Company, showed that the year 1938, in the United States, showed the lowest incidence of sickness in the whole history of any nation; also the lowest death rate. Moreover, the average death rate of sixty-two years showed the biggest step yet in advancing man's span of life."

Doctor Sleyster admitted that it was ironical that the sciences of medicine and sanitation had made human beings live longer, only to have them pose a new economic problem. "We have so much agitation over old-age pensions because we have so many more old people than we used to have," he remarked.

To Speak to Doctors

The new leader of the medical association is scheduled to talk before the Los Angeles County Medical Association on March 15. His topic will be "Socialized Medicine."—Pasadena *Star-News*, March 1.

* * *

Would Change System of County Hospitalization

County hospitals in California should be opened up to all classes of citizens, Mrs. T. N. Price, state chairman of the Farm Home Department of the Farm Bureaus, informed the directors of the San Luis Obispo County Farm Bureau in session Saturday.

Seeking the enactment of legislation affecting hospitals and state medicine, Mrs. Sims said the Farm Bureaus of the state wanted the county hospitals open to indigents who cannot pay, to citizens who can partially pay, to citizens who can totally pay. Mrs. Sims said the Farm Bureaus also wanted full-time superintendents to be appointed to devote all their time and attention to the hospital and not engage in private practice. These superintendents, she said, should either be under the direction of the county boards of supervisors or county welfare boards. Patients, she explained, should, however, be able to select their own favorite physicians to treat them in the county hospitals.

Mrs. Sims also said the Farm Bureaus were interested in the compulsory health insurance proposals, specifically one that provides for cash benefits as well as hospitalization.—San Luis Obispo *Independent*, March 3.

LETTERS

Subject: Hospital facilities in the United States.*

(COPY)

Chicago, Illinois, March 16, 1939.

To the Editor:—There are 1,272 counties without general hospitals registered by the American Medical Association. Of these 1,272 counties, approximately 250 have general hospitals not registered by the A. M. A.

Of the 1,196 counties without a registered hospital of any variety, 659 counties are entirely within a radius of thirty miles of a registered general hospital in neighboring counties.

There are only twenty-seven counties no part of which is within thirty miles of a registered general hospital. The population of these counties is 181,484.

Five hundred and ten counties lie in part within and in part without a circle of a thirty-mile radius surrounding existing registered general hospital facilities. Assuming that the population of these 510 counties is, on the average, half within and half without the thirty-mile radius, we have 2,691,288. Adding to this the 181,484 in the twenty-seven counties previously mentioned, we have 2,872,712 persons, or 2.2 per cent of the total population of the United States living more than thirty miles from a registered hospital.

In a like manner, in California the counties of Alpine, Mono and Lake, without a registered hospital within their borders, have approximately 4,500 persons more than thirty miles from a registered hospital.

We are assembling further material and shall forward it as soon as it is ready. Also, for your further information, I am enclosing a copy of "The Health of Forty Million People."

535 North Dearborn Street.

Sincerely yours,

R. G. Leland, M. D.,
Director, Bureau of Medical Economics.

Subject: Foreign medical school graduates in California.

Department of Professional and Vocational Standards
Board of Medical Examiners
State of California

San Francisco, California,
March 11, 1939.

To the Editor:—Enclosed please find Attorney-General's Opinion NS-1508, dated March 9, 1939, re foreign medical school graduates, which we think will be of interest to readers of California and Western Medicine.

With kindest personal regards, believe me

Very truly yours,

C. B. Pinkham, M. D.,
Secretary-Treasurer.

* * *

(COPY)

San Francisco, March 9, 1939.

Charles B. Pinkham, M.D.
Secretary-Treasurer
Board of Medical Examiners
515 Van Ness Avenue
San Francisco, California

Dear Sir:

In your communication of December 27, 1938, you refer to an applicant for medical licensure who, you state, graduated from Frederick-Wilhelm University in Berlin, Germany, June 6, 1919, and who filed, on February 1, 1938, with the California State Board of Medical Examiners, form numbers 172 and 173, said forms indicating such applicant's intention to qualify under existing California law for admission to written examination for physician's and surgeon's certificate following completion of the interneship required of foreign graduates pursuant to Section 2193 of the Business and Professions Code.

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* In reply to a letter from the Editor.

You recite that your records indicate the successful completion of 75 per cent of the required interneship as of November 14, 1938. You further recite that in checking the applicant's credentials you are advised by the American Consul at Berlin that the applicant's license to practice in Germany "expired" on September 30, 1938, and that you have since been informed that such so-called expiration was in accordance with a decree issued by the German Government canceling as of said date the medical licenses of all German Jewish doctors. You further recite that several prospective applicants are in the same position as the applicant involved, and you ask the opinion of this office as to whether the decree canceling all medical licenses issued to German Jewish doctors will prevent those German medical school graduates who started interneship in compliance with Section 2193 of the Business and Professions Code prior to the date of said decree, from being admitted to written examination on completion of said interneship. This question, you state, was raised "because of the requirement of the California Medical Practice Act that, in addition to other credentials, graduates of foreign medical schools seeking admission to a written examination for a California physician's and surgeon's certificate must hold a license to practice in the country wherein is located the medical school wherein they pursued their medical education."

In reply, please be advised it is the view of this office that the decree of the German Government to which reference has already been made will not prevent German Jewish physicians and surgeons who started interneship prior to September 30, 1938, from being admitted to written examination on completion of said interneship.

Subdivision (c) of Section 2193 requires that an applicant show "he has been admitted or licensed to practice medicine and surgery in the country where the institution in which he has pursued his medical course of professional instruction, is located."

There is no question but that the applicant referred to by you showed at the time of filing his certificate of commencement of interneship the fact that he had been admitted or licensed to practice medicine and surgery in Germany. There is, likewise, no question that he possessed every qualification at said time required of applicants for licensure, save and except that of completion of an interneship.

Under such circumstances, and in view of the fact that the deprivation of the applicant's foreign license is based only upon a political decree and was not due to any disqualification arising from any illegality or inefficiency in practice or any mental, moral or physical deficiency, it is our opinion that subdivision (c) of Section 2193 of the Business and Professions Code should be liberally construed and held to apply to the end that the Board of Medical Examiners should admit such applicants to written examination upon the satisfactory completion of their interneship.

Very truly yours,
Earl Warren, *Attorney-General.*
By Lionel Browne, *Deputy.*

Subject: Reserve assets and dividends of California State Compensation Insurance Fund.

(copy)

March 21, 1939.

To the Editor:—Material gains over the results of previous years were noted in the 1938 report of the State Compensation Insurance Fund as submitted to George G. Kidwell, Director of the Department of Industrial Relations and Chairman of the Industrial Accident Commission.

John C. Stirrat, Manager of the State Compensation Insurance Fund, reported that premium income from 45,000 California employers representing one-third of the insured payroll in the state amounted to $9,603,381.03.

Accident prevention activities and safety programs sponsored by the Fund eliminated a great amount of human suffering and economic loss. The consequent savings combined with a low administrative expense of only 13.80 per cent of the premiums, resulted in substantial savings to policyholders. *Dividends totaling $3,276,836.08 were returned during 1938.**

Admitting assets, the largest ever held by the Fund, totaled $16,861,968.07, an increase of $1,049,765.39 over the previous year. Under the California law an employee who is permanently and totally disabled receives a pension for life. Employees injured in 1914 and each succeeding year are still receiving compensation from the Fund. The reserve set aside for future benefit payments to employees injured prior to December 31, 1938, was increased to $10,573,866.76. This, both by statutory requirement and a check of individual claims, is sufficient to pay all deferred benefits to injured workers or their dependents.

The Fund is one of the largest taxpayers in the state. It is taxed on the same basis as a private insurance company. Over $2,500,000 has been paid in taxes to the state as a result of the insurance business transacted by the Fund. The Fund is not subsidized by the state in any way, owning its home office building, paying rent for its branch office quarters, telephone service, and for all other items of expense usually furnished other state departments.

In addition to a reserve of $2,350,000 for dividends accrued, but not yet due for payment, the Fund has a surplus of $1,685.061.68 to provide for catastrophe losses or other emergencies.

This surplus and reserves invested in high-grade securities are evidence of the Fund's financial ability to meet all its obligations to policyholders and their employees, and to meet any contingency which may arise.

The efficient operation of the Fund, manned by a staff of expert men and women, has caused this department to be accepted throughout the nation as an outstanding workmen's compensation carrier.

John C. Stirrat, *Manager.*

Subject: United States Public Health Service leaflets on syphilis.

(copy)

United States Public Health Service

Washington, February 27, 1939.

To the Editor:—You will recall that last spring the United States Public Health Service published Venereal Disease Folder Number One, "Syphilis—Its Cause, Its Spread, Its Cure." It was designed to provide the facts about syphilis for the layman, and to keep patients in treatment. It has proved effective. More than 800,000 copies already have been sold.

Now a companion folder has been published. It is called "Syphilis and Your Town" and outlines the essential points of a community control program. Copies of both folders are enclosed. The two folders together tell the whole story of syphilis for the layman. The disease, the treatment, the facilities each town needs to find and treat syphilis are outlined clearly and concisely.

Your interest in syphilis control has been active. "Syphilis and Your Town," with "Syphilis—Its Cause, Its Spread, Its Cure," can make your efforts more effective. Both folders have deliberately been made as inexpensive as possible in order that wide distribution may be attained. They may be obtained for one dollar per hundred copies from the Superintendent of Documents, Washington, D C.

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* Italics are our own.—Editor.

Respectfully,
R. A. VONDERLEHR,
Assistant Surgeon-General,
Division of Venereal Diseases.

Subject: Examinations for internes.

STATE OF CALIFORNIA
STATE PERSONNEL BOARD
Sacramento, March 2, 1939.

To the Editor:—The California State Personnel Board is anxious to recruit the best qualified persons for student interne and senior interne. To accomplish this we ask your help in publicizing Civil Service examinations for these positions.

There is no residence requirement for these examinations and no written test will be given. Applicants will be rated on education, experience, and appraisal of scholastic record. Applications may be filed at any time during 1939 and will be rated immediately. If a candidate's qualifications, after investigation, are acceptable, his name will be placed on the list of those eligible for employment in accordance with his rating.

An announcement in your journal about these examinations would, we feel sure, secure the interest of many qualified people who ordinarily would not hear about these openings. We are sending you a bulletin which gives pertinent information about the tests.

Your help in calling these examinations to the attention of medical students and internes will be invaluable to us.

1025 P Street.

Yours very truly,
LOUIS J. KROEGER,
Executive Officer.

* * *

(COPY)

FACTS CONCERNING EXAMINATIONS

Filing of Applications.—Applications filed at the office of the State Personnel Board must be filed not later than the close of the business day, December 30, 1939. Applications filed by mail must be addressed to the State Personnel Board, 1025 P Street, Sacramento.

Purpose of Examinations.—To obtain eligibles to fill anticipated vacancies at the various state institutions.

Location of Employment.—Vacancies may occur at any of the various state institutions located throughout the state.

Note.—Applications may be filed at any time during 1939 and will be rated as soon as they are received by the State Personnel Board. If a candidate's rating on education, experience, and fitness is high enough to qualify him in the examination, his name will immediately be placed on the eligible list in accordance with his rating.

Senior Interne

Duties.—Under the general supervision of a staff physician, to assist with the medical work in a state institution for the mentally diseased or deficient, by performing routine medical tasks, including making rounds of wards with a physician and assisting him in giving medical treatment to patients or inmates, giving first-aid treatments, assisting with minor and major surgical operations, giving anesthetics, tube-feeding patients, attending clinics and staff meetings, recommending to physicians therapeutic treatments for patients or inmates, doing pathological and x-ray laboratory work, keeping records and preparing histories of cases under observation and treatment.

Entrance Salary.—Fifty dollars a month and maintenance for self and family. Employees maintaining an efficiency rating of 80 per cent or better may receive, subject to availability of funds, annual salary increases of $10 until a maximum of $90 a month is reached.

Student Interne

Duties.—Under the immediate supervision of a staff physician, as a medical student, to assist with medical work in a state institution for the mentally diseased, by performing routine medical tasks, including making rounds of wards with a physician and assisting him in giving medical treatment to patients, giving first-aid treatments, assisting with surgical operations, tube-feeding patients, attending clinics and staff meetings, observing the treatment of special case assisting with pathological and x-ray laboratory work, keeping records and preparing histories of cases under observation and treatment.

Entrance Salary. — Twenty-five dollars a month and maintenance. Employees maintaining an efficiency rating of 80 per cent or better may receive, subject to availability of funds, annual salary increases of $5 until a maximum of $45 a month and maintenance is reached. . . .

Subject: The American Board of Internal Medicine, Inc.

Madison, Wisconsin,
March 8, 1939.

To the Editor:—The American Board of Internal Medicine would appreciate it very much if you will give publication in your next issue to the date of the next written examinations of the American Board.

1301 University Avenue.

Very sincerely yours,
THE AMERICAN BOARD OF INTERNAL MEDICINE, INC.
William S. Middleton, M. D.,
Secretary-Treasurer.

* * *

AMERICAN BOARD OF INTERNAL MEDICINE, INC.

Written examinations for certification by the American Board of Internal Medicine will be held in various sections of the United States on the third Monday in October and the third Monday in February.

Formal application must be received by the Secretary before August 20, 1939, for the October 16, 1939, examination, and on or before January 1 for the February 19, 1940, examination.

Application forms may be obtained from Dr. William S. Middleton, Secretary-Treasurer, 1301 University Avenue, Madison, Wisconsin.

Subject: Medical refugees.

San Francisco, March 20, 1939.

To the Editor:—As it was felt that much misinformation concerning the number of refugee physicians who have been licensed to practice medicine in California is current, the San Francisco Committee for Service to Émigrés asked me to procure authentic data on this subject.

A representative of the committee searched the records of the State Board of Medical Examiners, which were generously placed at our disposal by Dr. Charles B. Pinkham, the secretary of the Board, for the years 1933–1938, inclusive, *i. e.,* for the six years since the inauguration of repressive decrees in Germany. For the sake of completeness, all of those countries were included from which it was thought that refugees may possibly have come, i. e., Germany, Austria (1938), Hungary, Italy (1938), Czechoslovakia, and Poland. The figures for the countries other than Germany are, as can be seen from the data given below, negligible.

The physicians holding degrees and licenses from Germany who have been licensed in California are:

1933	2
1934	5
1935	17
1936	3
1937	16
1938	17
Total for six years	60

The figures for the other countries mentioned, considered for the entire six-year period, are:

Hungary 3, Austria (1938) 3, Italy (1938) 2, Czechoslovakia 1, and Poland 0. The numbers from these countries who have been licensed in California during these years are so small as to make them, as was stated above, negligible.

The sixty physicians licensed from Germany, even if all of them are considered as refugees, constitute less than two-thirds of one per cent of the 9,785 physicians registered in the state in 1938.

Of the sixty physicians registered from Germany, the distribution is: Los Angeles 17, San Francisco 25, other localities 17, unknown 1.

Very truly yours,
Medical Refugee Control Committee of the Western States.
Sol Hyman, M.D., *Executive Secretary.*

Subject: Proposed legislation on narcotic enforcement.

(copy)

Division of Narcotic Enforcement

San Francisco, March 18, 1939.

California Medical Association
450 Sutter Street
San Francisco, California

Gentlemen:

Following a survey that was made by the State Narcotic Enforcement Division of conditions surrounding the dispensing of narcotics by members of your profession, we found that there were numerous cases of forged prescriptions where the name of the prescribing physician had been used fraudulently on blanks provided for him by pharmacies.

Particularly in the southern part of the state, where these prescriptions were presented to chain-store druggists, no effort was made, on the part of the dispensing pharmacist, to check the authenticity of the prescription.

Naturally, I know, that if every narcotic prescription was to be checked by the pharmacist before dispensing the same, a great inconvenience would be caused to the patient and a great annoyance would be occasioned by the physicians; so, in view of these facts as were disclosed, it became imperative that something be done to stop this imposition by narcotic addicts and peddlers on innocent physicians and pharmacists.

With this in mind, I talked with Edward F. O'Day, Assemblyman from the Twenty-fourth District, and, with the coöperation of Dr. Charles B. Pinkham, Secretary of the Board of Medical Examiners, and Mr. John Ramsay, President of the Board of Pharmacy, a system was devised by which this evil could be corrected.

PROPOSED LEGISLATION

We propose that the State Narcotic Enforcement Division provide books to all persons legally entitled to prescribe narcotic drugs—the same to contain one hundred prescriptions, in triplicate form—the original of which would bear the official seal of the State of California watermarked on the back thereof. The prescribing physician would make all three copies at one time; the original and duplicate would be given to the patient, to be taken to the pharmacy to be filled, and the triplicate would be retained in the book and would be the permanent record of the prescribing physician. The pharmacist would note on the original the date on which the prescription was filled and retain this copy for his permanent record; the duplicate, on which he would note the same facts, would be sent, at the end of thirty days, to the State Narcotic Enforcement Division, at San Francisco.

In order to avoid any embarrassment that might be caused to a patient because of the fact that these forms might indicate to the patient that narcotics were being prescribed, it was decided that no mention would be made on the form relative to the nature of the prescription, but would be undisclosed in a phrase of this type: "This prescription is issued pursuant to Chapter ——— and ——— of the Statutes of 1939, and across the face of it, in large print, would be the words "non repetatur." We felt that this would remove any embarrassment between the physician and patient.

The book of prescriptions which will be supplied by this department, free of charge, will be of a convenient size that will readily fit into the pocket of the doctor.

In the case of an epidemic, or sudden or unforeseen accident or calamity, a prescription may be written upon a form other than the official prescription form.

Violations of the provisions of this Act are punishable as a misdemeanor.

The great amount of good to be derived from this system is that the State Narcotic Enforcement Division will, every thirty days, have a complete report of the narcotics dispensed, and can readily remedy any infractions of the medical code by cautioning the violator, thus preventing serious consequences to the violator. This would prevent the necessity of criminal action in most cases and its attendant notoriety.

I firmly believe that our State Division was never intended to police the medical, dental, and other professions concerned with the dispensing of drugs, and it is for this reason that, in sponsoring this act, the coöperation of the Medical Association, the California Dental Association, the State Board of Medical Examiners, the State Board of Osteopathy, the State Board of Pharmacy, and the State Society of Veterinarians have been asked to coöperate in supporting this greatly needed legislation.

In supporting this bill your Association would be doing a great public service in that it would permit our Division, which is seriously undermanned at the present time, to devote its entire time to the illicit narcotic traffic.

156 State Building.

Paul E. Madden,
Chief, Division of Narcotic Enforcement.

Subject: Constitutional limitations upon power of legislature to restrict or abolish State Board of Public Health.

(copy)

San Francisco, March 20, 1939.

J. B. Harris, M.D.
Medico-Dental Building
Sacramento, California

Dear Doctor:

At the recent meeting of the Committee on Public Policy and Legislation, we were requested to examine the California Constitution and applicable judicial decisions in order to determine whether or not it is within the power of the legislature either to abolish or greatly to restrict the powers of the State Board of Public Health.

It is our understanding that there are several bills now pending before the legislature which, if enacted, would either abolish the State Board of Public Health or greatly restrict its powers and duties with respect to public health.

Article XX, Section 14, of the California Constitution provides that: "The legislature shall provide, by law, for the maintenance and efficiency of a State Board of Health."

Article I, Section 22, of the Constitution states that: "The provisions of this constitution are mandatory and prohibitory, unless by express words they are declared to be otherwise."

The foregoing section has been held to mean that the word "shall" in any provision of the constitution renders that provision mandatory. *Chenoweth* vs. *Chambers*, 33 Cal. App. 104.

It has further been held by the California Supreme Court that the provisions of the constitution which are mandatory are binding upon every department of the state government—legislative, executive, and judicial. (*People* vs. *California Fish Co.*, 166 Cal. 576.)

Hence, it must be concluded that it is mandatory upon the legislature to provide, first, for the maintenance, and second, for the efficiency of a State Board of Health. Under the decision in *People* vs. *California Fish Company, supra,* it is clear that the mandatory language in Section 14 of Article XX is binding upon the legislature as well as upon other branches of the state government.

Hence, it is necessary to conclude that any legislative enactment abolishing the State Board of Public Health would be in conflict with the mandatory provisions of the constitution because any such legislation would be contrary to the constitutional requirement that the legislature must provide for the maintenance of a State Board of Health.

Further, it is necessary to conclude that any legislative enactment unduly restricting the powers and duties of the State Board of Health would likewise be in conflict with the constitution because, under the constitutional provision, the legislature is obliged to provide for the efficiency of the State Board of Public Health

There are no California decisions directly construing Article XX, Section 14, of the Constitution. However, Section 15 of Article XX, which relates to mechanics' liens, contains language very similar to Section 14. By Section 15 the legislature is required to "provide, by law, for the speedy and efficient enforcement of mechanics' . . . liens." It is to be noted that the language of Section 15 is practically identical with that of Section 14 in so far as imposing duties upon the legislature is concerned.

A number of California cases have construed Article XX, Section 15. It has been held that the section is self-executing (*Miltimore* vs. *Nofziger Bros. Lumber Co.*, 150 Cal. 790) and that "the remedy expressly authorized by the organic law cannot be frittered away by any legislative action or enactment." (*Young* vs. *Shriver,* 56 Cal. App. 653, at 655-6).

It is thus apparent that the courts have held that any legislative enactment tending to impair the right to mechanics' liens would be unconstitutional because of the self-executing nature of Article XX, Section 15, and because of the mandatory injunction upon the legislature to provide by law "for the speedy and efficient enforcement of such liens."

Since Section 14 contains the same language as Section 15, it is reasonable to suppose that it would be construed by the courts in the same manner as Section 15. If this should be the case, then it would undoubtedly be held that any legislative enactment "frittering away" the powers, functions, and duties of the State Board of Health would be considered unconstitutional because in conflict with the self-executing and mandatory provisions of the constitution requiring the legislature to provide by law for the "maintenance and efficiency of a State Board of Health."

We believe that the foregoing answers the inquiry submitted to us in regard to the powers and duties of the legislature with respect to the State Board of Public Health.

111 Sutter Street.

Very truly yours,
Hartley F. Peart
Howard Hassard

Know, or hearken to him who knows. You cannot live without knowledge, either your own, or borrowed, but there be many who do not know that they know nothing, and others who think that they know, but know nothing; such deformities of the mind are incurable, whence it is that the ignorant do not know themselves, thus failing to discover what they lack. Some would be wise, if they did not believe that they were, and so it comes to pass that even though the oracles of wisdom are few, they live in idleness. because none consults them; it does not dwarf grandeur, nor argue against capacity to seek advice, yea, to seek advice brings credit; better to debate in the mind. to avoid combat with misfortune—Baltazar Gracian, 1653.

MEDICAL JURISPRUDENCE†

By Hartley F. Peart, Esq.
San Francisco

Legal and Ethical Protection Given to Facts Made Known to a Physician in Confidence

In many instances a physician acquires knowledge of facts personal to his patient, which information the physician is bound never to disclose. However, since other information coming into his hands from a patient need not be kept inviolate, the question often arises as to which category particular facts belong. The Principles of Medical Ethics of the American Medical Association include the following:

> Chapter II. Section 1.—Patience and delicacy should characterize all the acts of a physician. The confidences concerning individual or domestic life entrusted by a patient to a physician and the defects of disposition or flaws of character observed in patients during medical attendance should be held as a trust and should never be revealed except when imperatively required by the laws of the state. There are occasions, however, when a physician must determine whether or not his duty to society requires him to take definite action to protect a healthy individual from becoming infected, because the physician has knowledge, obtained through the confidences entrusted to him as a physician, of a communicable disease to which the healthy individual is about to be exposed. In such a case, the physician should act as he would desire another to act toward one of his own family under like circumstances. Before he determines his course, the physician should know the civil law of his commonwealth concerning privileged communications.

The California Business and Professions Code, Section 2379, reads:

> The wilful betraying of a professional secret constitutes unprofessional conduct within the meaning of this chapter.

Other sections of the Code provide for the revocation of a physician's license upon proof of unprofessional conduct.

It can be seen that not only the ethics of the profession. but the civil law as well, has recognized a relationship of trust between a physician and his patient. The rules for admission of evidence in judicial proceedings recognize this fact, and to insure confidence and willingness on the part of the patient to lay before his physician all facts which might in any way assist in the treatment which the physician must render, extend a privilege to confidential communications between a patient and his physician. This privilege gives the physician the right to refuse to testify about such subjects, unless his patient consents to his doing so.

The physician-patient privilege has not always been extended. In the early English common law, confidential communications between attorney and client were protected to enable the attorney to obtain from his client a complete recital of facts, but such protection was not extended to the physician and patient relationship. California, however, by express Code provision, establishes a physician-patient privilege. Code of Civil Procedure, Section 1881, Subdivision 4, states that a physician cannot, without the consent of his patient, be examined in a civil action as to any information acquired in attending the patient, which was necessary to enable him to prescribe or act for the patient. However, the section makes the following exception to the general privilege: (1) Where a patient sues for damages for personal injuries, any physician who "prescribed for or treated" him may testify. (2) Where a patient is dead, and the executor or administrator, surviving spouse or children sue for wrongful death, the patient's physician may testify. (3) Where the patient is dead and his will is contested.

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† Editor's Note.—This department of California and Western Medicine, presenting copy submitted by Hartley F. Peart, Esq., will contain excerpts from and syllabi of recent decisions and analyses of legal points and procedures of interest to the profession.

(4) Where the patient is dead and an action is brought involving the validity of any instrument transferring real or personal property claimed to have been executed by him, in which case the physician may testify as to mental condition, and disclose any such information.

In addition to the statutory exceptions, many other elements have been held to affect the privilege. First of all, the privilege does not extend to criminal proceedings. Secondly, the information must be received in a professional capacity. Thirdly, the privilege only extends to information received in the actual treatment of a patient, not to information received during mere examination, unless the patient believes that the examination is being made for the purpose of treatment.

The privilege has also been held not to extend to various other matters, for example, family matters incidentally spoken of or overheard or observed by a physician while professionally attending a patient. Thus it was held in one case that a physician could testify in an action by a niece against the estate of her deceased aunt for services rendered the latter in whose home she had resided since early infancy, to statements made to him by the aunt who was his patient to the effect that she wanted to compensate plaintiff for such services. In another instance, it was held that a physician who had attended a testator could testify in a will contest as to the testator's expressed opinion as to his daughter's mental condition, she being the contestant of the will.

Probably the most important factor which a physician must keep in mind is that the patient may often be deemed to have waived the privilege. Thus, in making an attending physician a subscribing witness to his will, a deceased has been held to have waived the privilege and invited a full and proper examination of the matters and facts with respect to which the physician's lips would otherwise have been sealed. Again, if the patient permits the physician to give testimony without making any objection, or makes the physician a witness or voluntarily testifies to communications between himself and the physician, he is deemed to have waived the privilege. Once there is a waiver, the patient cannot later revoke it.

Another possible cause of waiver is the presence of a third party at the time the patient gives the physician the information sought to be protected. It is often held that the presence of the third party destroys the confidential nature of the conversation and that both the physician and the third party are released from any duty to refrain from later commenting upon the communications received. Nurses and professional assistants are treated somewhat differently from other types of third parties. If a nurse's presence is necessary to effect treatment, then her presence will not waive the privilege as to the physician. As to whether or not the assistant can speak, is an issue yet unsettled in this state.

Finally, it should always be remembered that it is the patient who is entitled to the benefit of the privilege, the physician being allowed to assert it only in the absence of assent by the patient. Thus, there is no privilege when the patient waives the privilege expressly or by implication as set forth above.

It is of interest to note that the privilege extended to communications between a physician and his patient are not extended to communications between a patient and one whose profession is curing by means of faith. (*Estate of Mossman,* 119 Cal. App. 404).

There is still an immense amount to be learned about health, but if what is at present known to a few were part of the general knowledge, the average expectation of life could probably be increased by about ten years—J. B. S. Haldane.

SPECIAL ARTICLES

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PNEUMONIA CONTROL*

A Report by the California Medical Association Committee

Your committee has carefully examined the pneumonia problem in the State of California and submits the following findings:

The death rate per hundred thousand population from all forms of pneumonia and from influenza in this state is 75.5. For the registration area, it is 102.5. From lobar pneumonia alone, the death rate in this state is 29.9.† In the registration area, it is 42.7. California, therefore, has a relatively low death rate from the pneumonias, and particularly from lobar pneumonia when compared with the other states. Nevertheless, we average about four thousand deaths a year from pneumonia, more than half of which are probably due to the pneumococcus. Recent improvements in diagnosis and therapy make it seem probable that a considerable percentage of deaths from pneumococcus pneumonia can be prevented.

Regarding total deaths from lobar pneumonia only for the six-year period, 1930 through 1935, this state lost an average of 1,862 persons a year. Forty-two per cent of these deaths occurred in Los Angeles and San Francisco counties. Fifty-four per cent of the deaths occurred in the northern counties of the state, and forty-six per cent occurred in the southern counties. Eighty-one per cent of the deaths occurred in only thirteen counties of the state as follows:

	Per Cent		Per Cent
Los Angeles	30	Fresno	3
San Francisco	12	San Bernardino	3
Sacramento	7	Imperial	2
Alameda	6	Kern	2
San Joaquin	5	Riverside	2
San Diego	5	Orange	1
Santa Clara	3		

It will be noted that, for the most part, these are the counties having reasonably adequate medical and hospital facilities.

Seventy-one per cent of these total deaths occurred under the age of sixty-five, showing that lobar pneumonia is not primarily a disease of old age.

There is considerable variation in the death rate per hundred thousand according to counties, ranging from Sacramento County with the highest death rate of 91.3 and San Joaquin with a death rate of 79.1, to San Mateo and Santa Barbara counties with a death rate each of 19.8. There appears to be a tendency for lobar pneumonia deaths to be commonest in certain of the valley counties, particularly Sacramento, San Joaquin, Madera, Tulare, and Imperial counties. The reason for this has not been determined as yet, but it is suspected that it may be related to the distribution of the transient population during the pneumonia season.

At the beginning of its work your committee found that the Neufeld rapid typing method, and the prompt administration of specific antiserum were not in general use by physicians throughout the state except in the larger metropolitan areas. Laboratory facilities for rapid typing were generally lacking and there was an inadequate supply of serum throughout the state. There was, likewise, a general lack of appreciation on the part of the practicing physicians of the state, of the newer scientific advances in this field. There was a decided tendency on the part of the general public to call a physician late in the course of the disease when serum therapy, even if available, would be less effective. One large life insurance company estimates that 50 per cent of its policyholders who die of lobar pneumonia have failed to call the physician before the fourth day after onset. This presents a serious problem in health education of the public to which your committee has given careful attention.

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* Report of the Committee on Pneumonia Control, subcommittee to Committee on Health and Public Instruction. Read at the Conference of California Medical Association Officers and Committees on February 25, 1939. See also report in Pre-Convention Bulletin Supplement.

† Average deaths per one hundred thousand population, 1930–1935, inclusive.

Another problem has been the fact that pneumonia deaths are reported to the State Board of Health on a pathologic basis—that is, as lobar or broncho—rather than on an etiologic basis. From the standpoint of therapy it is most important to differentiate those pneumonias due to the pneumococcus and those due to the streptococcus or other bacteria or viruses, regardless of the pathologic distribution of the lesion in the lung tissue.

To summarize the problem in this state as your committee now sees it:

1. Although more fortunate than most states, there is enough pneumonia in California to present a serious problem.
2. Many lives can be saved by the general acceptance on the part of both the physician and the public of modern methods of pneumonia diagnosis and treatment.
3. Physicians of the state are willing and anxious to apply these new methods, and are entitled to all the assistance their state and county medical societies can give them.
4. Laboratory facilities, while generally lacking outside the larger cities, can be made more accessible and more generally available.
5. The supply of specific antiserum is now adequate to supply the needs of the physicians of the state.
6. Pneumonia deaths should be reported on an etiologic, rather than a pathologic, basis.
7. There is great need for mass education of the public concerning the seriousness of pneumonia and the importance of calling a physician early in the course of the disease.

With these findings at hand, your committee has proceeded to attack the problem as follows, bearing in mind two fundamental principles which were unanimously agreed upon early in the course of the committee's deliberations: (*a*) The pneumonia control program should be conducted by existing agencies, for the most part, rather than through the organization of any new agency; (*b*) pneumonia control need not be hampered by differences of opinion concerning the treatment of the indigent or the determination of those who are not indigents, and a satisfactory result can be accomplished through the individual practicing physician without destroying any of his rightful prerogatives.

Since the individual physician who is treating pneumonia can best be helped by his own local county medical society, a letter has been addressed to each county society in the state, calling their attention to the seriousness of the problem and offering the assistance of this committee and of the Committee on Postgraduate Activities to each society interested in the subject.

The Committee on Postgraduate Activities has included in its program of courses offered county medical societies a section on pneumonia, and is working with this committee in compiling a list of competent clinicians available to address county medical societies on this subject.

The State Board of Health and the various local health departments throughout the state have been contacted, local health officers being urged to work in close coöperation with their local county medical society. The State Board of Health has been requested to prepare a list of laboratories throughout the state which are considered competent to do Neufeld rapid typing. The State Board of Health has also been requested to change the system of reporting pneumonia deaths from a pathologic to an etiologic basis. If this can be done, your committee will attempt to use the facilities of the California Medical Association to bring about compliance with this new regulation by all physicians in the state.

The four medical schools in the state have been addressed on this subject and requested to include appropriate courses in their undergraduate teaching, as well as to assist this committee with postgraduate teaching where and when necessary. The California State Nurses' Association has been addressed, calling their attention to the seriousness of the pneumonia problem and the fact that skilled nursing is essential in pneumonia therapy. It has been suggested to them that they appoint a special committee on the subject to work with this committee in assisting their members.

Considerable time has been given to the subject of educating the general public. As fast as local medical societies and local health departments have become interested in the problem and willing to have a public education campaign carried on, they have been put in touch with various agencies to accomplish this purpose. Thus, in San Francisco, one of the newspapers carried a series of articles prepared by the Pneumonia Committee of the Western Branch, American Public Health Association, on the subject of pneumonia, pointing out to the public the importance of calling a physician early in order to take advantage of the newer methods of therapy. Some months later a popular film on pneumonia treatment was introduced into the neighborhood theaters of San Francisco, and this has been shown to a total audience of sixty thousand.

In Los Angeles County the Fox-West Coast Theater chain and the Independent chain have shown a popular film on pneumonia to total theater audiences of eighty thousand. The attention of all county medical societies has been called to the importance of conducting some form of popular education on this subject in their respective localities.

Full use has been made of the facilities of the office of the secretary of the California Medical Association, and the valuable assistance of the secretary and his staff are highly appreciated.

A scientific exhibit on pneumonia control will be planned and conducted by the members of this committee.

With your approval the committee will continue along the lines outlined above. In addition to this, and as soon as possible, your committee will attempt to collect and tabulate the experience of various hospitals throughout the state in an effort to determine the types of pneumococcus pneumonia which are most prevalent; and we shall also attempt to collect experience on the use of oxygen therapy and the newer sulfanilamid preparations in drug therapy. For this purpose it would be most helpful if the committee might have a small budget, not to exceed $250, to permit the assembling of a quorum, either in San Francisco or Los Angeles, at more frequent intervals than has been possible in the past.

Roy E. Thomas, M.D., *Chairman.*

ILLNESS AND TIME LOSS FROM OCCUPATION

The time loss from disabling illness and accidents is about three times greater in the population of working ages on relief than in selfsustaining families above the $1,500 income level, according to findings of the National Health Survey of the United States Public Health Service, announced by George St. John Perrott, director of the survey.

"Adults between 25 and 64 years of age in relief families were disabled for 21 days per capita in the survey year, while the rate at these ages in families receiving $1,500 and over was six to seven days per capita," Mr. Perrott stated.

The aged (65 years and over) in relief families experienced disabling illness aggregating about eight weeks per capita, compared with three to three and one-half weeks per capita for old persons in upper income families. It was pointed out by directors of the survey that these figures represent minimum rates because they take into account only the days of disability accruing from illnesses disabling for a week or longer.

Disability caused by sickness and accidents has serious implications for adults between 25 and 64 years of age because this group represents largely the working population of our country, including housewives and men and women workers outside the home. The results of the survey show that the excess in the amount of disability among persons of these ages in low income families is especially high from the chronic diseases. This constitutes an added economic burden because many of the chronic diseases are "high-cost" illnesses, requiring extensive diagnostic facilities and specialized medical treatment.

Included in this chronic group are the so-called degenerative diseases. These diseases disable people of the working ages (25 to 64 years) in relief families almost four days per capita annually while the rate is two days per capita for the nonrelief groups receiving less than $1,000, and only about one day per capita for the economic groups receiving $1,500 a year and up, according to Health Survey findings.

Disability from rheumatism in the 25 to 64 age group causes about two days of incapacity per person in a 12-month period in relief families, one day per capita for the $1,000 and less nonrelief group, and about one-half day per capita for those receiving $1,500 and up. In this same age group, nervous and mental diseases, excluding cases in institutions for a year or more, cause two days' loss per capita in a year in the relief families; about one and one-half days for nonrelief families receiving less than $1,000; and about six-tenths of a day, for the families above the $1,500 income level.

The survey shows that disability rates from respiratory diseases, including such diseases as pneumonia, influenza, and colds, for adults of the working ages (25-64) are two and one-half times higher in the relief group than they are in families receiving $1,500 a year and over.

Accidental injuries and orthopedic impairments resulting from accidents and disease also affect especially the working ages from 25 to 64, and wide differences are noted in the amount of disability from those causes in the low and high income groups. Accidents account for three times as much disability per capita among relief families, and about twice as much in the low-paid nonrelief families as they do in the families which have incomes of $5,000 a year and over.

The contrast in disability rates for orthopedic impairments is even more pronounced. Persons in relief families have disability rates for orthopedic impairments five times as high as the rates for families receiving $3,000 and over a year; rates for nonrelief families living on incomes of $1,000 and less a year are almost four times as great as the $3,000 and up economic class.

The National Health Survey was a project conducted by the United States Public Health Service with the aid of financial grants from the Works Progress Administration. These reports are based on a house-to-house canvass of some 800,000 families, including 2,800,000 persons in 83 cities and 23 rural areas in 19 states. The survey was made during the winter (largely from November to March) of 1935-36.

The total surveyed population was so distributed as to give a sample which was, in general, representative of cities in the United States according to size and region. In large cities (100,000 and over) the population to be canvassed was determined by a random selection of many small districts based on those used in the United States Decennial Census of 1930. In the smaller cities selected for the study, the population was enumerated completely.—U. S. Public Health Service Bulletin.

TULAREMIA*

With reports for November and December, 1938, the two months of greatest prevalence, not yet available, a total of 613 cases of tularemia were recorded in 1938. This figure does not include cases occurring in Illinois, Ohio, Virginia, and Kentucky, where, for the past twelve years, the highest incidence has been reported.

"While tularemia does not represent a major health problem," says Dr. A. M. Stimson, Medical Director, United States Public Health Service, "nevertheless, the fact that so much distress and mortality could have been avoided by reasonable precautions, renders the subject more interesting than the numbers imply. There had been 8,000 cases with 396 deaths reported up to 1938."

Discovered in 1910, named in 1920, and elucidated from beginning to end by Public Health Service investigators, human cases of tularemia have been recognized everywhere in this country except Connecticut and Vermont. In the decade after 1925, it was variously reported in Japan, Russia, Norway, Sweden, and Austria.

An acute infection disease caused by the *Bacterium tularense* (after Tulare County, California, where first found), it occurs under natural conditions in over twenty kinds of wild life, with cottontail, snowshoes, and jack rabbits the chief reservoirs and direct causes of over 90 per cent of the human cases in this country. Man becomes infected by contact of his bare hands with the raw flesh and blood of these animals, or by bites of blood-sucking ticks and flies which have previously fed on infected animals.

Hunters, market men, cooks, and housewives become infected when skinning or dressing wild rabbits. Their bare hands may become covered with blood when they pull out the livers and spleens. If by chance there is an open sore or cut on the hands, the infection may enter the wound on the hand and cause the disease. When a rabbit is shot, its bones often become shattered into sharp fragments. If, in dressing an infected rabbit, one of these fragments of bone pierces the skin of the hands, the infection may enter at that point.

About three days after exposure to such a wound infection, illness begins with headache, chilliness, vomiting, aching pains, and fever. The patient may think that he has influenza and go to bed. The sore on the hand, or elsewhere, develops into an ulcer. The glands at the elbow or in the armpit become enlarged, tender, and painful, and later may develop into an abscess. There is sweating, loss of weight, and debility. The illness lasts ordinarily about three weeks, and is followed by a slow convalescence which may extend two or three months. Most patients recover without any bad after effects, but about 5 per cent die, especially if the case is complicated by pneumonia.

One who has recovered from an attack of tularemia need not fear a second attack, because he is then immune to the disease. There is no record of a second attack in man. There is only one record of the transfer of the infection from man to man. Doctors, nurses and attendants caring for the sick have not contracted the disease.

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* References on Tularemia in CALIFORNIA AND WESTERN MEDICINE:

Tularemia—R. H. Creel, Volume 29, No. 4, October 1928, page 267.

Tularemia—C. L. Stealy and David Miller, Volume 30, No. 6, June, 1929, page 418.

Tularemia in Nevada—J. C. Geiger and K. F. Meyer, Volume 31, No. 1, July, 1929, page 38.

Tularemia in Cattle and Sheep—J. C. Geiger, Volume 34, No. 3, March, 1931, page 154.

Tularemia—George R. Magee, Volume 39, No. 6, December, 1933, page 421.

Psittacosis and Tularemia—Volume 44, No. 2, February, 1936, page 79.

Tularemia in California—Hiram E. Miller, Volume 42, No. 4, April, 1935, page 236.

Tularemia has no seasonal prevalence except as it is influenced by insects or by contacts with infected animals. Laboratory infections may occur at any time. Human cases are most prevalent in summer time in the western states where ticks and deer flies are the cause of infection. Human cases, due to infection from dissecting jack rabbits, are likewise most prevalent during April to October, because these are the months of greatest destruction of these pests. Each of the Mississippi, cottontail rabbits are responsible for most human cases, and since they are generally protected by law except during a few winter months, the seasonal prevalence is apt to be November to January, when the hunting season is on.

Rabbits raised under domestic conditions and sold for food or for pets, have never been found naturally infected. They are just as susceptible to artificial inoculation in the laboratory, however, as are the wild rabbits.

The prevention of tularemia is almost entirely a matter of personal precaution. No curative or preventive serum has been perfected. Sick or dead wild animals which are found should not be handled; forget about the rabbit which you can stalk on foot and knock over with a stick. Any carcasses in which peculiar whitish spots are found on both liver and spleen should be discarded and buried or burned.

Keep the bare hands out of a wild rabbit. The bacillus of tularemia does not require a wound for its entry, but can go through the healthy skin. Sometimes infection is contracted by rubbing the eyes with soiled fingers.

Rubber gloves afford reasonable protection to those who must dress wild rabbits and other animals, but sharp fragments of rabbit bone can easily pierce a rubber glove and puncture the hand. Employ immune persons when contact with infected material is necessary.

Thorough cooking of all wild game, especially rabbits, is essential. Infected meat is rendered harmless for food by thorough cooking, but if any red juice is allowed to remain about the bones, the germs will remain alive and virulent.

The liberal use of soap and water and disinfection of the hands are recommended to remove rabbit blood from the hands, or even when the hands have come in contact with the rabbit's fur.

NATION ENJOYS BANNER YEAR FOR HEALTH*

A year ago, in a similar statement for Science Service, I said that the health outlook for 1938 was altogether favorable. This prediction was based on the remarkable health record established for 1937 among industrial policyholders of my company.

My optimism was more than justified, for no previous year has even closely approached the record for low mortality established for 1938.

Month after month the death rates among these insured wage-earners and their families have been even lower than during 1937, and at the middle of December we find a year-to-date death rate that is over 7 per cent below the previous minimum, as established only a year since.

What happens among these many millions of people is a pretty sensitive index of health conditions in the country, as a whole. So, even if I had no other source of information I could say that 1938 has been an extraordinary health year in the United States. But, as a matter of fact, information for the first nine months of the year is available from the health officers of thirty-nine states. The story they tell is that, without a single exception, every one of these states has shown improved mortality as compared with 1937—and in many instances very marked improvement.

Principal factors in bringing this about were the much lower mortality rates from respiratory diseases and the gratifying accomplishments of the campaign to reduce the automobile accident toll.

NEW LOW RECORDS

The death rates from tuberculosis, pneumonia, and influenza have reached new United States minima during 1938. It is almost certain that the mortality from tuberculosis will drop below 50 per 100,000 for the first time in history.

If the present rate of decline continues for a few more years, tuberculosis will reach the stage where the number of open cases will no longer be sufficient to maintain it among the leading causes of death in this country.

There has been no more striking instance of the success of the public health movement than the decline in the tuberculosis death rate during the last four decades. The time is now ripe for a final and intensified drive leading to the effective suppression of this disease.

There were no major epidemics of influenza or pneumonia in 1938, a year marked by the wide adoption of the new serum treatment against the more prevalent types of pneumococcus.

Inasmuch as respiratory disease tends to hasten deaths from cardiac, vascular or renal conditions, a natural consequence was the fall in mortality from most of the chronic diseases of old age. The sole exception to this rule, in 1938, was the continuance of the rise in deaths charged to coronary artery disease. But this increase may be only apparent, reflecting improved diagnosis together with the newly awakened interest of physicians in this form of heart disease and an increasing tendency on their part to give coronary disease prominence as the chief cause of death when associated with other conditions.

AUTOMOBILE DEATHS LOWER

Among the most gratifying aspects of the mortality picture for 1938 was the marked decline in automobile fatalities. Present figures indicate that the final tabulation will show fewer deaths by one-fifth from this cause than were recorded in 1937 and this will mean about eight thousand lives saved.

Further gains against both infant and maternal mortality also contributed to the salutary state of public health during the past year. It is safe to report new minimal death rates in both of these important fields of public-health work.

Only disturbing feature is the continued increase of the cancer death rate. Nineteen hundred and thirty-eight is the twentieth consecutive year, with a single exception, to register a rise.

There is some doubt, however, as to whether this upward trend in cancer deaths actually marks an increase of the disease or merely reflects the rapid aging of our population. Since cancer is a disease that is confined largely to the later years of life, it is certain that much of the apparent rise is attributable to the increasing proportion of old people in the general population. Improved means of diagnosis and more accurate reporting also have been important elements in the apparent increase in cancer mortality.

FEWER INFECTIONS

Turning to the sickness side of the subject we find a gratifying situation also. All but two of leading communicable diseases showed below-normal prevalence during 1938. The country was especially blessed in that it was comparatively free of that scourge of childhood, poliomyelitis (infantile paralysis). Less than 1,700 cases were recorded throughout the entire country and no section has suffered what might be called a major outbreak.

Only measles and smallpox were unusually prevalent during the current year. Fortunately, neither of them was responsible for much mortality, although the exceptionally low death rate from measles in 1937 was probably quadrupled in 1938.

The smallpox situation, however, cannot be passed over so lightly. The rate has been steadily climbing during the last four years. Why do some communities persist in taking serious risks when smallpox can be avoided so easily by community-wide vaccination?

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* By Dr. Louis I. Dublin.

Will the present favorable health conditions continue during the coming year? In general, I think they will.

So much depends upon the occurrence of major epidemics, weather conditions and other "acts of God," that no one, of course, can now predict the final outcome.

On the whole, the augury for the coming year is most propitious. At no time in the history of our country have there been so many signs of popular interest in public health affairs. The widespread and active campaign against venereal disease, the ambitious program advocated by the American Tuberculosis Association, and the successful National Health Conference at Washington in July, all emphasize the keen interest that is being manifested in communal and individual health.

Barring unforeseen and uncontrollable acts of nature, 1939 should prove to be another milestone on the road to better health and longer life for our people.—San Francisco *News*, January 2, 1939.

SYPHILIS IN INDUSTRY

The United States Public Health Service has advocated a six-point program to prevent the spread of syphilis among employees in industry. The recommendations are as follows:

1. Routine blood tests for applicants for employment.
2. Routine blood tests at the time of periodic reëxamination of employees.
3. Industry, with its compact organization, should develop a vigorous educational program.
4. Industry should extend its educational campaign into the field of prophylaxis.
5. There is a responsibility upon the industrial medical officer to see that adequate modern treatment is available to employees at prices ordinary wage earners can afford. If such treatment is not available in private practice or at public clinics, industrial medical service should undertake such treatment.
6. Syphilis must at all times be handled as merely another communicable disease. The privacy of relations between the worker and the medical service should be preserved in the best professional tradition. In ordinary cases it cannot be regarded as ground for discrimination of any kind against employees, when treatment is properly required.

Dr. R. A. Vonderlehr, Assistant Surgeon General in charge of the Venereal Disease Division, stated that when syphilis cases are given proper treatment, industry runs a minimum of risk of having workers disabled or partially disabled from the disease. A recent survey showed that symptoms of syphilis of the nervous system resulted in only 1.6 per cent of the properly treated cases under observation. For untreated cases the rate was 16.9 per cent.

Those studies also revealed no cases of syphilitic heart disease among the group that had received proper treatment, while 3.4 per cent of the cases having no treatment developed heart trouble during the ten- to twenty-year observation period.

"Fortunately," Doctor Vonderlehr says, "some of the larger industries have discovered that the control of venereal diseases in industry can hardly be accomplished by dismissals. They assure the worker that so long as proper precautions are taken during the early stages and proper treatment continued, there will be no dismissals following discovery and treatment of infection.

"Some industries have established clinics to treat both infected employee and his family. Those industries have found out that the employee constantly in fear of being dismissed will neglect treatment and that this neglect simply leads to prolonged and more serious illness. A sick and worried employee is very definitely a liability, at least in terms of inefficiency and possibly in terms of accident and labor turnover.

"Remember, also, that from the public point of view, the patient's continuance of treatment and, therefore, his cure will depend upon the continuance of his income. Nobody would benefit by his discharge. He might easily be thrown upon public relief. That might result from a policy of needlessly discharging syphilitics from their employment.

"The syphilitic person passes through three definite stages: early, latent or symptomless, and late syphilis. If adequate treatment is given to the infected individual, the manifestations of late syphilis are prevented in more than 80 per cent of all cases.

"From the standpoint of incapacitation as a result of syphilis with reference to employment, it should be noted that only those people with very early syphilis—in the first week or two of the disease—and those who have manifestations of late syphilis, might have a lowered earning capacity. The number of syphilitic persons in these categories, however, would not constitute more than 10 per cent of all the syphilitics in the United States."

The greatest proportion of people so infected, Doctor Vonderlehr explained, have the latent or symptomless form of the disease. Thus, unless a special attempt were made to detect the disease through the use of serological blood tests, the average employer would not be able to tell which of his workers were infected.

In its very early stage, before he begins to receive treatment, the patient may have symptoms present which will cause some degree of incapacitation for a few days. These disappear, however, within a week when the patient is given modern treatment, and these treatments should not interfere with his job.

In late syphilis, of many years' duration, serious complications involving the brain, spinal cord, or the heart and great blood vessels may occur, in which event the patient would, of course, likewise be incapacitated. This incapacitation would last for a variable time and might possibly be permanent. A great many of the people with such complications are confined to mental or other hospitals more or less permanently and are not a part of the great employed group in this country.

Statistical biography of ten thousand children born in any one year:

Who Die—

1,323 die before the age of twenty.

Who Live—

34 are crippled.
15 Are deaf or hard of hearing.
5 are blind.
17 are visually handicapped.
260 have defective speech.
86 are so emotionally unstable or delinquent that substituted care is needed.
8 are so mentally defective, dependent, or delinquent that institutionalization is needed.
78 are mentally deficient, and in need of special classes.
347 are mentally handicapped, and in need of opportunity classes (vocational level—manual labor).
1,214 are dull normal, and in need of occupational classes (vocational level—semiskilled trades).
5,206 are normal, and fit into regular grades (vocational level—skilled trades and small businesses).
1,301 are bright, making a college education usually desirable (vocational level—larger business enterprises and professions).
20 are sufficiently gifted to make professional and research education highly desirable.

TWENTY-FIVE YEARS AGO†

EXCERPTS FROM OUR STATE MEDICAL JOURNAL

Vol. XII, No. 4, April, 1914

From Some Editorial Notes:

Of Utmost Importance to You.—The coming meeting of the State Society at the Potter Hotel, Santa Barbara, April 14, 15, and 16, will be in many ways the most important session ever held. Problems of the widest range and of the deepest importance of any ever confronting us will come up for discussion and for action. And we must meet them and settle them in some way; the duty cannot be shirked or put over, and a general line of policy must be adopted which can be followed by the Council and the officers in their conduct of the work during the year. Every delegate should attend, even if at some personal sacrifice of time and money on his part, and every county unit should see to it that delegates are elected who will surely attend the meeting and transact the work which will be presented. It is not fair for a county to fail of representation and then kick at what may be done; the time to kick is right there at the meeting of the House of Delegates, and possibly the delegate from the smallest unit may have just the right suggestion to make in regard to some pending matter. Certainly, he should be there and express his views. This is no time in which to think of personal jealousies or little differences of opinion; changes have come and great changes are coming within the next few years, and we must recognize that fact and meet the changes that are here and get ready for those that will be with us before we know it. . . .

There is every reason to believe that we can work these things out so as to do justice to everybody concerned; but we cannot do it if you just sit back and kick at what is.

* * *

Our only Hope.—The only hope for holding up the medical profession and medical conditions in this state today is in holding up and increasing the strength of the State Medical Society. As the Journal said two or three years ago, the time will come (it has almost come now) when membership in the State Society will have to take the place of the official license to practice. . . .

* * *

Medical Defense.—We must recognize the fact and be prepared for it, that the number of suits for alleged malpractice will increase very largely in the near future—in fact is already on the increase. There are a number of reasons why this should be so. More people who are hurt will be treated by physicians; the injured person may not sue the employer and so many unscrupulous lawyers will be deprived of these "contingent fee" cases. There is left only one person who may be sued—the physician; and the same sort of cheap and scaly lawyer who would incite the patient to sue the employer will turn his attention to starting a suit against the doctor. . . .

* * *

The Accident Insurance Situation.—Representatives of the State Society, the San Francisco County Society, the State Commission, and of several insurance companies, have had a number of long conferences during the last month and have come to a better understanding of the case and to a tentative agreement that seems to offer a clearing up, to a great extent, of many of the apparent difficulties. . . .

A word of caution to our county medical societies. Do not pass resolutions of an arbitrary and pugilistic nature;

(Continued in Front Advertising Section, Page 15)

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† This column strives to mirror the work and aims of colleagues who bore the brunt of Association activities some twenty-five years ago. It is hoped that such presentation will be of interest to both old and new members.

BOARD OF MEDICAL EXAMINERS OF THE STATE OF CALIFORNIA†

By Charles B. Pinkham, M.D.
Secretary-Treasurer

News

"Superior Judge Martin I. Welsh today heard oral arguments on a petition for a writ of mandate, which, if issued, will serve to force the California Board of Education to certify osteopathic physicians and surgeons as school health supervisors. The writ is sought by Dr. Edward William Jordt, thirty-eight, to force his appointment as supervisor of health and development in the Anderson Valley Union High School at Booneville, Mendocino County. The petition for the writ was filed by Attorney John L. Brannely. Deputy Attorney (General) Ralph Cowing presented arguments for the Board of Education. Brannely contends the Board's policy in restricting the appointment of school physicians to medical doctors certified by the California State Board of Medical Examiners is discriminatory. Judge Welsh indicated he will ask both attorneys to file briefs in support of their arguments." (Sacramento *Bee,* March 3, 1939.)

"Legal action, compelling, if sustained by the courts, recognition of osteopaths and chiropractors on the panel of the health plan of the City Health Service was threatened today. David T. Jones, representing the Affiliated Chiropractors of California, said that Attorney Newell Hooey would take what legal action he deemed necessary. . . . The threatened legal action is based, according to Jones, on the contention that the plan when voted in, gave the right to a choice by the employee. . . ." (San Francisco *Call-Bulletin,* February 16, 1939.)

"Complaint that the Health Service Board has refused chiropractors equal consideration with physicians and surgeons in San Francisco's group health insurance program for employees and their dependents was contained in a Superior Court suit on file today by Dr. Lloyd H. Garrison, chiropractor. Doctor Garrison asked a writ of mandate to compel the Board to include chiropractors in the so-called plan No. 1. A supplemental, separate suit was filed by Muriel M. S. Pettit, a city employee, asking for the right to receive chiropractic treatment either under plan No. 1 or under a separate plan without discrimination." (Oakland *Tribune,* March 8, 1939.)

"Felony charges will be issued against anyone caught attempting to influence the Superior Court jury trying Dr. T. Maud Ramer on charges of performing an illegal operation, Judge Edward J. Kelly warned from the bench yesterday. It was the second time during the six days of the trial that Judge Kelly had issued stringent admonitions to spectators and interested persons. On the first occasion a typewritten slip containing propaganda favoring birth control had been turned over to the judge by jurors who found it in a wash basin in a rest room. Judge Kelly said investigators for the district attorney's office were seeking the persons who left the paper and that they would be prosecuted if discovered. Charges that a medical examiner had threatened to 'bankrupt' her prior to the time of her arrest were made by Doctor Ramer during argument over the appointment of the expert witnesses after the jury had

(Continued in Front Advertising Section, Page 24)

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† The office addresses of the California State Board of Medical Examiners are printed in the roster on advertising page 6.

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The infusion of dextrose and saline solutions need not be a problem. Baxter's give you solutions that are safe and pure and sterile . . . in the handy Vacoliter . . . always ready . . . swiftly administered.

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Hearing Acuity.—Only about half the adult population of the nation claims to have normal hearing, according to random samplings made in connection with recent United States Public Health Service surveys.

Findings announced also revealed that only 56 per cent of these people who think they hear perfectly passed audiometer tests for normal hearing. Many failed to hear the very high and the very low tones.

Wide differences were found among men and women. In general, women detect the high tones better, but fail to hear sounds in the lower range. Men do well in detecting low tones, but frequently show loss of hearing for high-pitched sounds.

The investigation was conducted as a phase of the National Health Survey, and in coöperation with prominent ear specialists. Hearing tests and ear, nose and throat examinations were given to about nine thousand persons drawn at random from the population in twelve cities.

The most frequent defect among these persons who erroneously believed their hearing to be normal consists in loss of hearing above the range of sounds most commonly used in human speech, that is, above an audiofrequency level of 3,000 cycles per second.

It was demonstrated through tests with bone conduction vibrators, placed on the mastoid bones, that these losses for high tones are due to primary degeneration of the acoustic nerve. This degeneration results from infectious processes associated with certain systemic diseases—such as scarlet fever, meningitis, diphtheria, influenza, and the like—as well as from local infections of the middle ear (otitis media). The common head cold is a frequent cause of these middle-ear infections.

The study of hearing loss among persons having noticeable impairments of hearing for speech reveals many new facts. Loss of hearing due to congestion and lesions of tissue in the middle ear, without accompanying injury to the acoustic nerve, is found to be characteristic of deafness among children of public-school age. Practically all deafness among persons over twenty-five years of age involves some degree of nerve degeneration. This degeneration is more localized among males and rather widely distributed throughout the ear among females.

In terms of hearing loss as measured with the audiometer, females show typically a rather uniform loss of hearing for all tones from about 100 cycles up to 8,000 cycles. Males, on the other hand, show characteristically greater losses than females for tones higher in pitch than 2,000 cycles. Males also show relatively less loss of hearing than females for tones that are lower in pitch than 1,000 cycles.

Knowledge of this consistent difference between males and females with impaired hearing is of considerable importance to the manufacturer of hearing aids. A much different type of instrument is required in most cases for males and females. In the case of males, hearing aids should typically amplify sounds above 1,000 cycles relatively more than those below this frequency level. For females, hearing aids should amplify sounds in a fairly uniform ratio through the frequency range from 200 to 4,000 cycles. Instruments now available on the market do not take these facts into account, directors of the hearing study said.

There were but ten deaths from malaria registered in California in 1937, and six deaths from this disease in 1936. Only half of these deaths occurred in the interior regions of the state, the rest of them occurring in coastal regions, whence the patients presumably had migrated for treatment.

Without health life is not life; it is only a state of languor and suffering—an image of death.—Rabelais.

OLEUM PERCOMORPHUM (Liquid)

10 and 50 cc. brown bottles in light-proof cartons. Not less than 60,000 vitamin A units, 8,500 vitamin D units (U.S.P.) per gram. 100 times cod liver oil* in vitamins A and D.

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Especially convenient when prescribing vitamins A and D for older children and adults. As pregnancy and lactation increase the need for vitamin D but may be accompanied by aversion to large amounts of fats, Mead's Capsules of Oleum Percomorphum offer maximum vitamin content without overtaxing the digestive system. 25 and 100 10-drop soluble gelatin capsules in cardboard box. Not less than 13,300 vitamin A units, 1,850 vitamin D units (U.S.P.) per capsule.

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FOR GREATER ECONOMY, the 50 cc. size of Oleum Percomorphum is now supplied with Mead's patented Vacap-Dropper. It keeps out dust and light, is spill-proof, unbreakable, and delivers a uniform drop. The 10 cc. size of Oleum Percomorphum is still offered with the regulation type dropper.

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More Important Now Than Ever Before.—When Dextri-Maltose was marketed in 1911 "without dosage directions on the package," Mead Johnson and Company of Evansville, Indiana, pioneered the principle that infant feeding was a therapeutic problem. Up to that time far more babies were fed by grandmothers, neighbors, grocers, and commercial houses than by physicians. This Mead policy was not readily accepted in the beginning, and it took many years of unceasing effort before the weight of the majority medical opinion finally led to mandatory action on the part of the Committee on Foods in 1932, whereby all makers of baby foods are now obliged to omit dosage directions. The Mead policy, however, does not stop here. It embraces other principles with which all physicians interested in the private practice of medicine are in agreement, such as: (2) No descriptive circulars in packages, or in shipping cartons (for druggists to hand to patients). (3) We supply no display of Mead products for druggists' windows and counters. (4) We do not advertise Mead products to patients. (5) We give no handbills and send no letters concerning Mead products to patients. (6) We do not broadcast to the public. (7) We refer patients to physicians at every opportunity. (8) We devote a great deal of effort and resources to research and to activities that assist the private practice of medicine. Is the Mead policy worth while?

Mental Hospital Survey.—Headquarters of the Mental Hospital Survey Committee will be transferred from New York to the United States Public Health Service in Washington next July in order to coördinate its activities with those of the Government's Mental Hygiene Division.

This committee was formed in 1936 to survey as many as possible of the 356 public mental hospitals in this country and Canada, to promote research and encourage wider distribution of teaching facilities in psychiatry and neurology. Offices of the committee were first established in connection with the National Committee for Mental Hygiene in New York, and the work has been carried on through funds provided jointly by the Rockefeller Foundation, the American Psychiatric Association, and the Public Health Service.

The original organizations represented on this committee were the American Psychiatric Association, American Neurological Association, American Medical Association, American Board of Psychiatry and Neurology, National Committee for Mental Hygiene, the United States Public Health Service, the Canadian National Committee for Mental Hygiene, and the Canadian Medical Association. Dr. Samuel W. Hamilton, Director of the Division of Hospital Surveys of the National Committee for Mental Hygiene, is medical director of the committee, and Dr. Grover A. Kempf of the Public Health Service is associate medical director.

The aim of the Mental Hospital Committee survey is to discover defects as well as good points in the various hospital systems. By the practical application of information gathered, it is the purpose to effect improvement in the care and treatment of mental patients as well as in the study of mental diseases in the various States and thus to raise the standards to a level commensurate with the importance of the whole problem.

The committee has already surveyed 169 institutions in forty states, and discovered a wide diversity in technical facilities and scientific treatment. In some of the states, for example, hospitals were found to lack proper equipment and operating with inadequate personnel and administrative organizations.

By directing attention to such matters, some betterment in methods of treatment for the mentally ill has resulted. Much work remains to be done, however, in collecting survey data and applying it to the correction of defects in existing hospital systems.

●

CANNED FOODS FOR INFANT AND EARLY CHILD FEEDING

● Milk is the basic article in the diet of the infant and young child. Breast milk is preferred for infant feeding. However, circumstances commonly require that other types of milk, properly formulated and supplemented, must be used.

Because of the wide range of digestive tolerance possessed by most infants the various types of formulas used routinely are usually tolerated by the majority of infants. But, in any group of infants started on a specific formula, there is always a certain number of "non-conformists." A recent study(1) has rationalized the problem of infant feeding by formula in the following statement:

> "More stress has been placed upon the various milks and their properties than on infants and their tolerance. Nutritional research has advanced sufficiently to adapt effectively the required type of milk to the individual infant rather than the infant to the milk."

Thus has been aptly expressed the trend in modern pediatrics towards the use of "individualized" rather than standardized formulas.

Because of many desirable properties such as its uniformity in composition and its physical properties after homogenization and heating—as well as its ready availability and economy—canned evaporated milk has been successfully used for many years in infant feeding. The value of such milk in some instances where individualized feeding is required has also been clearly indicated(1).

There appears to be no uniform agreement among pediatricians as to the exact time of life when other foods should be added to the milk diet. Nevertheless, it is agreed that early but judicious addition of properly prepared soups, cereals, fruits and vegetables is extremely desirable to increase mineral and vitamin intake and to improve gastro-intestinal motility. The psychological value of the early addition of a variety of foods in the formation of proper dietary habits in later childhood is also recognized.

When other foods are to be added to the exclusive milk diet attention might well be directed to the long list of specially prepared canned infant foods. Such foods manufactured by closely controlled procedures from selected raw materials include a full line of soups, cereals, fruits, vegetables, and many food combinations.

The nutritive values of these canned infant foods have been established not only by studies in the laboratory(2), but also by clinical researches(3, 4). Such foods—together with canned evaporated milk—provide reliable, economical and convenient means for formulation of diets for early child or infant feeding.

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230 Park Avenue, New York, N. Y.

(1) 1937. Am. J. Digestive Diseases, Nutr. 4, 240.
(2)a. 1933 J. Am. Diet. Assn. 9, 295.
b. 1934. J. Nutrition 8, 449.
(2)c 1936. Ibid. 12, 405.
d. 1936. J. Am. Diet. Assn. 12, 231.
(3) 1932. J. Pediatrics 1, 749.
(4) 1938. Am. J. Diseases Children 55, 1158.

We want to make this series valuable to you, so we ask your help. Will you tell us on a post card addressed to the American Can Company, New York, N. Y., what phases of canned foods knowledge are of greatest interest to you? Your suggestions will determine the subject matter of future articles. This is the forty-seventh in a series, which summarize, for your convenience, the conclusions about canned foods reached by authorities in nutritional research.

The Seal of Acceptance denotes that the statements in this advertisement are acceptable to the Council on Foods of the American Medical Association.

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Wisconsin Experiment in Coöperative Medicine.—The Douglas County (Wis.) Medical Society, in coöperation with the State Medical Societly of Wisconsin and the Coöperative Health Association at Superior, has concluded an agreement to provide members of the association with complete medical and surgical care on a prepayment basis for a period of trial and study, *The Journal of the American Medical Association* for January 14 reports.

In the preface to the agreement that was signed, the following statements were made:

In September, 1938, the State Medical Society of Wisconsin adopted the report of its Special Committee to study the distribution of health service and sickness care in Wisconsin. That report recommended that there be instituted under the direction of a special committee and the local county medical society, and with the assistance of lay groups actively interested in proposals dealing with new methods of the delivery of sickness, care, experimental voluntary plans providing sickness care on a prepayment and voluntary basis. To assure that any such plan create no health hazard to those seeking services under it, and to make certain that any subscriber should obtain those services contracted to be given, even though the fee basis should prove inadequate and the compensation not that which the Cooperative expects, the State Medical Society adopted as a requirement that the local medical society stand guarantor that the services be given and their quality be high. In other words, the actual reserve would be the physicians of the community. The State Medical Society of Wisconsin and the Douglas County Medical Society have agreed that the Coöperative Health Association of Superior offers a proper situation for such experiment, and thus the two medical societies and the Coöperative state these principles, in the form of articles of agreement, to be followed in developing such a voluntary plan in Superior, Wisconsin.

The agreement provides that those who become members of the Coöperative Health Association shall have free choice of physician among the members of the Douglas County Medical Society; that a joint conference committee be established to meet regularly to discuss problems that may arise; that not more than 20 per cent of the membership dues shall be subject to administration charges; that 80 per cent of the gross income should be earmarked for physicians' services, and that no more than 300 units would be encompassed in the trial. Units may represent individual membership or family memberships. The total number of people participating in the trial, it is estimated, will reach a total of 1,200 individuals. The amount of monthly dues has not as yet been established by the Coöperative Health Association. However, $3.00 a month for complete medical and surgical care for an entire family has been tentatively considered. For a couple or for a single person the dues would be less. The plan does not include hospitalization costs, as the members of the association plan to avail themselves of the state-wide group hospitalization plan now being effected by the society in coöperation with the hospital associations. The society emphasizes that the premiums established were accepted by it "without expression of judgment" as to sufficiency. The plan does not limit the participants to any stipulated income group.

Prevalence of Syphilis.—One person out of every hundred in the United States is infected with syphilis and nine more out of every hundred will acquire syphilis at some time in life if present rates prevail, Miss Lida J. Usilton, Senior Statistician of the United States Public Health Service recently declared at a meeting of the New York Chapter of the American Statistical Association at the Hotel Woodstock, in New York City.

In discussing the subject, "Do Ten in One Hundred Have Syphilis?" Miss Usilton stated: "The estimate on the number who have acquired syphilis is 1 in 100. The estimate on the number who under existing detection and treatment facilities will acquire syphilis at some time in life is 10 in 100. This has been aptly expressed as 'syphilis strikes one out of every ten adults.'"

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The Public Health Service arrived at its figures through studies of authorized treatment sources in 1936-1937. The surveys included records from 8,700 physicians and 300 clinics, hospitals, and institutions. These treatment centers served approximately six million people.

Highest rates for acquiring syphilis are found in the group 20 to 24 years of age. The figures for this age level show an annual attack rate of 5.97 per 1,000 population.

The next highest group is that from 25 to 29 years of age, with an annual attack rate of 5.24 per 1,000. Rate for 15 to 19 years of age is 2.66 and for 30 to 34 is 3.80 per 1,000. Computations in this summary, as outlined by Miss Usilton in her presentation to the statisticians of New York do not include inherited syphilis.

The Federal Health Service surveys found no syphilis acquired under ten years of age, and rates for people above fifty were found to be extremely low, varying from 0.49 at 55 to 64 years down to 0.17 for the 70 to 79 age group.

The total number of people at all age levels who have acquired syphilis was computed at 1,407,180. This means an average of 11.46 per 1,000 for all age groups based on the 1930 census figures.

"Growing Pains" in Children.—The so-called growing pains in children have been variously interpreted as a normal phenomenon or as a manifestation of rheumatic fever, *The Journal of the American Medical Association* for January 14 says in an editorial.

Recently Hawksley reported an analysis of 115 cases of growing pains based on an examination of 1,000 children seen in London and Birmingham. Sixty-four of these 115 were subjected to follow-up examinations four years after the initial examination. Although no definitely associated diseases were discovered, there was commonly a history of frequent colds and coughs with coincident exacerbation in pains, signs of general but vague ill health, rather frequent minor orthopedic deformities, some fibrositis in certain cases and psychologic maladjustment. In conjunction with the 189 cases followed up by Sheldon and the sixty-four here reported, cardiac rheumatism was revealed to have developed in less than 0.8 per cent.

Hawksley concluded that the syndrome of growing pains is not related to rheumatic fever or subacute rheumatism and does not provoke rheumatic carditis. The pains may be associated with a number of conditions which can usually be discovered and treated by ordinary clinical methods.

This work finds substantial agreement with a similar study reported by Shapiro at the June meeting of the American Rheumatism Association. Shapiro made a follow-up study at the Lymanhurst heart clinic of 200 children who complained only of leg pains. The pain characteristically comes on at the end of the day and often awakens the patients during the night. Laboratory studies give normal results. None of Shapiro's patients developed rheumatic heart disease. He concluded therefore that this syndrome, which is so common during healthy school childhood and adolescence, is due to normal growth and clearly not to rheumatic fever.

The discussion following this paper indicated general accord on the nonrheumatic nature of most so-called growing pains. In the light of these more recent observations, great skepticism should be attached to a diagnosis of rheumatic fever in those children whose only symptoms consist in vague muscular pains and aches in the lower extremities.

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Of Alaska's 14,000 Eskimos, at least 60 per cent have tuberculosis in either the incipient or the active stage, and in some sections of the territory the percentage is even greater.—*Hygeia.*

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The First Annual Congress on Industrial Health.—"Early in the deliberations of the Council on Industrial Health its members determined to hold a series of conferences to aid in clarifying the objectives of the industrial health movement," *The Journal of the American Medical Association* for January 21 says in an editorial. The first Annual Congress on Industrial Health was conducted January 9 and 10 in Chicago.

"Part of the Council's plan for the advancement of industrial health is a stimulation of clinical discussions on industrial medical problems through the state and county medical organizations. There has been no forum particularly designed for the consideration of nonclinical problems of administration and integration. These may, on occasion, be fully as troublesome as diagnosis and treatment. The first conference of the Council dealt with these problems. As discussions are continued and regular opportunity is supplied for expression of opinions on industrial health by all interested members in the profession, the usefulness of these conferences will become apparent.

"The keynote of the first congress was contained in the report of the chairman of the Council on Industrial Health, Dr. Stanley J. Seeger, who pointed out that the practicing physician must attempt to orient himself in this expanding field. The aims and accomplishments of other organized agencies must be made plain. The progress of industrial medicine must be appraised periodically. Its scope and interrelationships must be constantly reëmphasized and redefined. The program of this first conference undertook to express the points of view of organized medicine and of the principal professional, governmental and lay agencies responsible for the health of the working population.

"Approximately 250 leaders in industrial health attended. Industrial medicine has progressed greatly in twenty-five years. Within the profession a career in preventive industrial practice is recognized increasingly as a worthy aim in itself. There was every indication that lay organizations welcomed the opportunity to learn at first hand the attitude which organized medicine takes toward industrial practice. There can be no essential incompatibility between their purposes and those of the medical profession which the conference table cannot solve. This method is much to be preferred to any legislative approach. Likewise it was frequently and emphatically expressed that organized medicine, both through tradition and structure, has a preëminent opportunity and responsibility to exert a salutary effect on standards and training in the sphere of industrial medical practice."

Flying Hospitals Are Uncle Sam's Speediest and Newest Medical Aids.—Flying hospitals—speediest and newest of Uncle Sam's medical aids—are maintained at eight air bases along both coastlines and the Gulf of Mexico, according to an article by S. R. Winters of Washington, D. C., in the February issue of *Hygeia, The Health Magazine*.

Twenty-one seaplanes are poised ready to answer medical calls from ships at sea. Aid to injured sailors and passengers and removal of persons from disabled vessels are the usual services they render. "NCU," meaning "any Coast Guard unit," is the radio call that summons one of these planes. This request for medical assistance is given right-of-way.

The idea was first put into practice a few years ago when five seaplanes, known as flying lifeboats, began their task of rescuing human lives out at sea. The planes carry a crew of four, and twenty passengers may be accommodated in an emergency. They are constructed to make landings on rough seas if necessary. Each one is equipped with a collapsible lifeboat and has stretchers for removing the injured from ships. The planes are met at their landing field by ambulances to rush the patients to the nearest hospital.

In addition to these services the planes endeavor to warn people of impending danger and assist extensively during floods and other disasters by transporting serums and biologic supplies and scouting the afflicted areas for purposes of operation planning.

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High Standards Require Free Choice of Physician.—In a summarization of more than fifty years' experience in providing medical care of the poor and unemployed by the City of Newark, New Jersey, published in *The Journal of the American Medical Association* for February 4, Charles V. Craster, M.D., D.P.H., Health Officer of Newark, draws the following conclusions:

"Under the free dispensary and district physician plan the cost of service is kept at a low figure, the average for a physician's call is between 90 cents and a dollar and clinic treatments average 25 cents. This service does not allow any choice of physician, and the quality of service rendered has a tendency to deterioration. With very few exceptions the reaction to a paid salary is to minimize as far as possible the extent of the service rendered. This can be understood when one considers the excessive calls for mdical treatment that are made on salaried physicians at certain seasons of the year. The 'off' period, when service calls are infrequent, are too soon forgotten by the salaried man.

"Another serious objection to the salaried physician is the attitude of the public. The term 'poor doctor' has not been forgotten, and frequently discourtesy, unfriendliness and actual hostility of the patient's family await the visit of the district physician. This attitude is not so prevalent when the physician demands and receives a fee for each attendance, which is much more in conformity with medical practice.

"The free choice of physician is in my opinion essential for a proper relationship between the doctor and the patient. Whatever framework is set up for the medical care of the employed and the unemployed, it should meet the following conditions:

"1. A service of reasonable cost to the community in which the physician should be willing to receive a fair standard fee for his services.

"2. Free choice of physician.

"3. Creation of a division of medical care in all health departments with an advisory committee appointed by the local county medical society.

"4. All dispensary services to be standardized, with physicians paid for actual services instead of annual salaries.

"5. A medical advisory board appointed by the county medical society to advise and correlate dispensary services.

"6. A pharmaceutical board appointed by the state pharmaceutical society to standardize and correlate the cost of medical prescriptions given to private pharmacies.

"7. The creation of a position of director of medical care who could be a physician or layman of exceptional ability to supervise and coördinate all the various branches and specialties of medical care and to advise on problems affecting hospital care."

Social Normalcy Required for Rehabilitated Cripple. A normal place in society, rather than an extension of his status as a dependent, should be the goal for the rehabilitated cripple, Mather Cleveland, M.D., New York, says in the February issue of *Hygeia, The Health Magazine.*

Overdone kindness, in the form of entertainment, excursions, food and clothing, may give the crippled child the feeling that he is entitled to more than his share of attention, the author warns.

"Prolonged association with other cripples and constant comparison of achievement on a scale which is below standard have a tendency to make him unfit to assume his place in the community," Doctor Cleveland points out. The author believes, therefore, that the home environment is preferable whenever possible, although the financial burden necessary for proper surgical care, education, and psychologic and vocational training should be shifted to the community.

Today, a normal life for the cripple is possible because of the increased concern of society with his problem. Whereas primitive tribes do not allow sickly or deformed children to survive, modern society strives for rehabilitation of the cripple and for the prevention of crippling diseases. Infantile paralysis, estimated to cause from 29 to 35 per cent of crippling among children, is being fought in many laboratories and clinics. Tuberculosis, which ranks second, is definitely declining after a prolonged campaign.

"Our yearly toll of accidents which produce child and adult cripples is so appalling that it merits our most serious study," says the author.

The plight of the adult, crippled after maturity by accident or disease, is often worse than that of the child cripple, who receives more attention. "To be turned in an instant from a self-supporting, self-reliant individual into a helpless dependent is a shocking experience which requires great courage to face," Doctor Cleveland declares.

Out of 5060 infant deaths recorded in 1937, 1437 occurred during the first day of life. By causes, these early deaths are as follows: diseases peculiar to early infancy, 1301; congenital malformations, 110; venereal diseases, 12; other general diseases, 8; external causes, 4; pneumonia, 2.

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Postmortem Examinations' Importance Is Stressed. "For many years, leading physicians and scientists throughout the United States have emphasized the importance of the postmortem examination, not only as a means for advancing medical science but also for the benefits this will confer in prolonging the lives of other human beings," an editorial says in the February issue of *Hygeia, The Health Magazine.*

"*The Readers Digest* for February provides strong support for postmortem examinations in a discussion, by Messrs. Pro and Con, of this highly important subject. Apparently Mr. Pro has all the best points on his side of the argument. He points out, for example, that postmortem examination is a stimulus to more scientific and complete diagnoses. The postmortem examination serves as a check on the competence and on the work of the physician. A postmortem examination, through detecting the source of an infection, may contribute to the public health by giving opportunity to a health officer to eliminate that source of infection. This has been proved repeatedly in relationship to epidemics and outbreaks of infectious diseases. Mr. Pro, for example, reports the case of a girl who died of severe infection with trichinosis. The postmortem examination disclosed this fact. A search was made to find the roadside stand from which the infested pork was purchased. Thus the danger was eliminated.

"The postmortem examination, Mr. Pro empasizes, is of vital significance in training young physicians. In the necropsy room they learn to see the end results of disease, as well as disease processes in various stages. This makes possible a vision in the mind of what goes on beneath the skin while the patient is still living. Moreover, it is significant, Mr. Pro points out, that our leading medical institutions are those with the highest percentage of examinations on the patients who die.

"Now postmortem examination is not compulsory in this country. The decision is left to the family. Doctors do not favor too much compulsion. They prefer to depend on the enlightenment of the people who follow medical opinion because they understand and believe. When the public understands the importance of the autopsy, not only for the future health of the family concerned but also for the advantage to medical science, the people can be depended on to cooperate.

"*Readers Digest* has done a notable service in reaching its vast clientele with this message. In brief the message is, 'Scientific investigation of the bodies of the dead brings dividends to the living.' "

High Consumption of Tomato Juice.—Each person in the United States consumed approximately 54 ounces of tomato juice in 1937, according to production figures released in an article, "Vitamin C via Tomato Juice," in the January issue of *Hygeia, The Health Magazine.* These show that 13,444,162 cases of canned tomato juice were packed that year.

It is best to buy the size can that is adequate for one meal, the article says, since after the can is opened and the juice is exposed to the air, its high vitamin C potency decreases.

There is about two and one-half times as much vitamin C in an ounce of fresh orange juice as in an ounce of canned tomato juice; but as canned tomato juice costs less than fresh orange juice, the cost per vitamin C equivalent is less, at most seasons, if canned tomato juice is used.

In addition to vitamin C, canned tomato juice is rated by the Council on Foods of the American Medical Association as an excellent source of vitamin A and a good source of vitamin B, and contains vitamin G. A four-ounce serving of tomato juice provides approximately one-fourth of the daily allowance for vitamin A, one-eleventh of the daily allowance of vitamin B. and about one-twenty-fifth of the daily allowance of vitamin G.

Home canned tomato juice may have as much vitamin value as commercially canned tomato juice, provided it is canned by proper methods.

In a sense, life is like a stream: If its outlet is dammed in one direction, it will seek another outlet or will overflow.—*Hygeia.*

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"Spectatoritis" Is Great American Disease Today.—"Sititis" or "spectatoritis" is the great American disease today, says James Edward Rogers, director of the National Physical Education Service of the National Recreation Association, who writes of "The New Day and the New Education" in the February issue of *Hygeia, The Health Magazine.*

We spend too much time looking and not enough time doing. All of us are sitting at our work and sitting at our play, the author says, which, of course, does not help our physical growth and development. Today, many physical breakdowns are due largely to the sedentary life that young and old are living as a result of modern labor-saving devices.

Modern civilization, therefore, forces the need for health and physical education in our public schools. The open spaces are rapidly disappearing; hence we must have playgrounds and athletic fields. Boys and girls, when they become adults, will be attendants to automatic machines and consequently will not get exercise in their work as their fathers did.

One is always more vexed at losing a game of any sort by a single hole or ace than if one never had a chance of winning it. This is, no doubt, in part or chiefly because the prospect of success irritates the subsequent disappointment.—Hazlett.

As knowledge with regard to the effects of food upon man increases it is more conceivable that the races that first avail themselves of the new handicaps of disease lengthen their lives, and so become leaders of the future.—Victor G. Heiser.

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Michigan Society Acts on Medical Care Plans.—The House of Delegates of the Michigan State Medical Society, at a special session held in Detroit on January 9, approved the principles of group hospitalization and group medical service and empowered the Society's Council, in coöperation with hospitals and civic groups, to proceed with the establishment of plans for the formation of nonprofit organizations to provide these two types of service.

The group protection would take the form of insurance with rates and benefits fixed according to actuarial studies. Rates for the hospitalization plan would probably range, for care in a ward, from 60 cents a month for a single subscriber to $1.25 a family. Benefits would include twenty-one days' hospital care for the first year.

For the suggested medical service plan, an employed subscriber would be entitled to a maximum block of units of service, with an alternative plan based on a time consideration.

Nineteen Hundred and Thirty-Eight Brings Lowest Infant Death Rate for California.—Infant mortality, during the first nine months of 1938, achieved a new record in California. There were 3,248 infant deaths during that period, as compared with 3,741 infant deaths recorded during the first nine months of 1937. The rate, based upon the number of infant deaths per 1,000 live births, was 42.8 for the nine months under consideration.

The infant mortality for white infants during this period was 36.5. For Mexican infants it was 78.7, as compared with 120.5 for the first nine months of 1937. Mexican infant deaths dropped from 1,116 in 1937 to 771 in 1938.

Among the counties in which conspicuous reductions in the numbers of infant deaths occurred are: Fresno, Imperial, Kern, Kings, Los Angeles, Monterey, Riverside, San Bernardino, San Joaquin, San Mateo, Santa Clara, Santa Cruz, Stanislaus, and Tulare.

It must be remembered that the trend of the infant mortality rate depends upon the number of live births, and with large numbers of births registered the infant mortality is, naturally, lower. Births, during this period, increased about 10 per cent in number.

To be sure, widespread and intensive activities in the prevention of infant deaths are carried on assiduously throughout the state. It is interesting to note that the decreases in infant mortality rates are in many of those counties where activities in infant care have been most intensive.

The following tables give the infant mortality rates by counties for the first nine months in 1937 and 1938, as well as by race and rates:

INFANT MORTALITY—BY COUNTIES
January to September Inclusive

County	1938	1937
Totals	3,248	3,741
Alameda	214	206
Alpine	....	....
Amador	3	5
Butte	33	24
Calaveras	3	4
Colusa	5	8
Contra Costa	30	33
Del Norte	4	2
El Dorado	3	4
Fresno	139	179
Glenn	3	2
Humboldt	29	29
Imperial	115	137
Inyo	3	11
Kern	122	197
Kings	36	56
Lake	1	8
Lassen	14	11
Los Angeles	1,038	1,163
Madera	33	31
Marin	9	4
Mariposa	....	....
Mendocino	16	18
Merced	39	42

(Continued on Page 48)

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(Continued from Page 46)

Modoc	13	2
Mono	1	....
Monterey	41	60
Napa	5	2
Nevada	11	6
Orange	94	97
Placer	9	18
Plumas	8	11
Riverside	84	107
Sacramento	91	88
San Benito	8	16
San Bernardino	110	153
San Diego	115	116
San Francisco	200	195
San Joaquin	74	98
San Luis Obispo	20	15
San Mateo	11	20
Santa Barbara	61	55
Santa Clara	77	122
Santa Cruz	9	27
Shasta	16	13
Sierra	1	....
Siskiyou	14	6
Solano	13	17
Sonoma	27	19
Stanislaus	35	60
Sutter	18	20
Tehama	6	7
Trinity	3	1
Tulare	86	102
Tuolumne	8	10
Ventura	68	78
Yolo	8	7
Yuba	11	19

INFANT MORTALITY—BY RACE AND RATE

January to September Inclusive

Race	1938		1937	
	No.	Rate	No.	Rate
Totals	3,248	42.8	3,741	53.6
White	2,281	36.5	2,390	41.8
Negro	68	54.9	77	67.8
Indian	40	115.3	56	174.4
Chinese	13	32.3	19	48.3
Japanese	44	37.5	41	38.0
Mexican	771	78.7	1,116	120.5
Filipino	27	79.4	28	101.1
Others	4	29.6	14	90.0

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BREWERS YEAST EXTRACT
B VITAMIN COMPLEX
EXTRINSIC FACTOR

FOR THE VITAMIN B COMPLEX ON THE HOSPITAL TRAY

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Vegex is ideal for the hospital tray, for the liquid diet, the drink between meals. It supplies the full vitamin B complex, is palatable, easily borne and economical.

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In clinical use, Vegex has been an aid in neurological conditions including alcoholic polyneuritis, in gastro-intestinal disorders needing the B vitamins, for the extrinsic factor in the anemias. There is mass human clinical use in all of these.

Vegex was the pioneer in finding the relation to and the need of enough of the Vitamin B Complex for child growth; for normal lactation.

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So easily is it borne that it is used as a liquid diet in post-operative cases. Physicians report its use in pneumonia. Its B vitamins are more and more readily available than in the dried brewers' yeast. In the job of bringing back the patient's strength, Vegex is a distinct aid.

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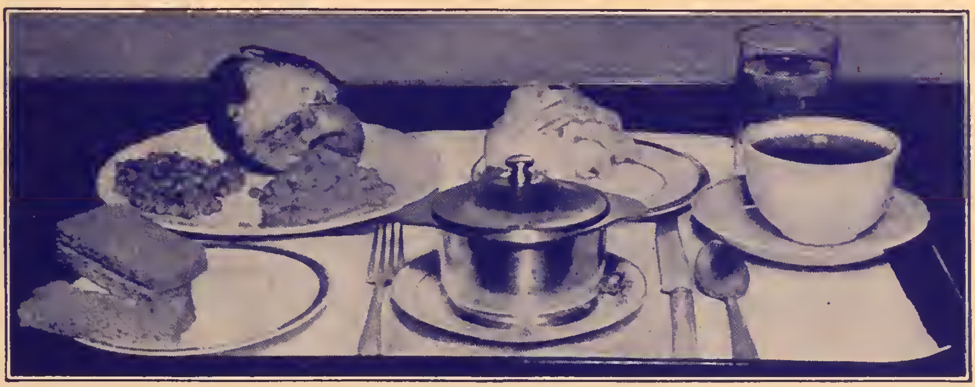
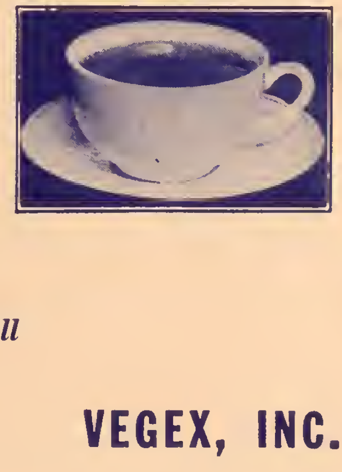


Babies: Mix from a half to two-thirds of a teaspoonful in a cup of hot (not boiling) water. Add two teaspoonfuls or equal proportions to the nursing bottle of milk. It is immaterial if all is given in two or three feedings.

"Babies take it greedily" (Plimmer)

For older children: Mix into soup, noodles, gravies, butter. Vegex amply, dependably adds the independent growth factor which the B Complex and only the B Complex supplies.

For the nursing mother: When two to four teaspoons are indicated; in neurological conditions and for the extrinsic factor where from a half to an ounce a day is indicated, serve Vegex in the soup and a scant teaspoonful in a cup of hot water or milk before breakfast, as the liquid between meals and before retiring.



Vegex is refreshing chilled or jellied in summer.

●

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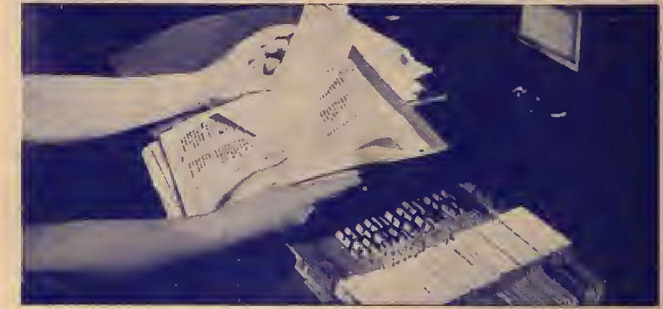

4 **THE TEST SLIP** is usually mailed to the Cutter Allergy Staff, who compare it against their compiled case histories from your locality.

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OF MEDICINE

CALIFORNIA AND WESTERN MEDICINE

Official Journal of the California Medical Association
FOUR FIFTY SUTTER, ROOM 2004, SAN FRANCISCO

VOLUME 50
NUMBER 5

MAY · 1939

50 CENTS A COPY
$5.00 A YEAR

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Owned and Published Monthly by the California Medical Association
Copyright, 1939, by the California Medical Association
"Entered as second-class matter at the post office at San Francisco, under the Act of March 3, 1879." Acceptance for mailing at special rate of postage provided for in Section 1103, Act of October 3, 1917, authorized August 10, 1918.

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C. O. Tanner (1939), 3255 Fourth Street, San Diego.

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Philip K. Gilman	San Francisco	1939

Members of the Auditing Committee are appointed each year by the Chairman of the Council.

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Benjamin W. Black	Oakland	1940
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W. Earl Mitchell	Chair., Com. on Hospitals, Dispensaries, Clinics
Philip Stephens	Chair., Com. on Industrial Practice
George G. Reinle	Chair., Com. on Medical Defense
George D. Maner	Chair., Com. on Membership and Organization
John H. Graves	Chair., Com. on Medical Economics
Junius B. Harris	Chair., Com. on Public Policy and Legislation
Alson R. Kilgore	Chair., Cancer Commission
John C. Ruddock	Chair., Com. on Postgraduate Activities
William W. Roblee	President of California Medical Association
Charles A. Dukes	President-elect
George H. Kress	Secretary-Treasurer

Communications for the Public Relations Department should be addressed to the Director, George H. Kress, M. D., Room 2004, 450 Sutter Street, San Francisco.

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Henry J. Ullmann	Santa Barbara	1939
Clarence G. Toland	Los Angeles	1939
Charles A. Dukes	Oakland	1940
Lyell C. Kinney (Vice-Chairman)	San Diego	1940
Otto H. Pflueger (Secretary)	San Francisco	1940
Orville Meland (Sec'y for Southern Section)	Los Angeles	1941
A. Herman Zeiler	Los Angeles	1941
Gertrude Moore	Oakland	1941

Communications for the Cancer Commission should be addressed to the Secretary, Otto H. Pflueger, M. D., Room 2004, 450 Sutter Street, San Francisco.

(Roster lists of officers of scientific section, component county societies. Woman's Auxiliary, A. M. A. delegates, special committees, etc., are continued on advertising pages 4 and 6.)

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(County society secretaries are requested to promptly notify "California and Western Medicine" when changes are indicated in their roster information.)

Alameda County Medical Association
2404 Broadway, Oakland

President, Frank H. Bowles, 426 Seventeenth Street, Oakland.

Secretary, Gertrude Moore, 2404 Broadway, Oakland.

Meeting, *Third Monday, 8:15 p. m., Hunter Hall, Oakland.*

Butte County Medical Society

President, E. L. Meyers, Fourth Street and Broadway, Chico.

Secretary, J. O. Chiapella, 131 Broadway, Chico.

Meeting, *Second Thursday.*

Contra Costa County Medical Society

President, Kaho Daily, 314 Tenth Street, Richmond.

Secretary, Clifford E. Dieterich, 1306 Pomona Avenue, Crockett.

Meeting, *Second Tuesday, 8 p. m.*

Fresno County Medical Society

President, Roland W. Dahlgren, 1006 Mattei Building, Fresno.

Secretary, Lester R. Nielson, 1006 Mattei Bldg., Fresno.

Meeting, *First Tuesday, University-Sequoia Club, Fresno.*

Humboldt County Medical Society

President, Samuel P. Burre, 507 F Street, Eureka.

Secretary, Joseph S. Woolford, 350 E Street, Eureka.

Meeting, *First Thursday.*

Imperial County Medical Society

President, Henry B. Graeser, 115 E. Fifth Street, Holtville.

Secretary, William A. Clarke, Holtville.

Meeting, *Third Tuesday, 7 p. m., Barbara Worth Hotel, El Centro.*

Kern County Medical Society

President, C. I. Mead, Haberfelde Building, Bakersfield.

Secretary, C. S. Compton, 428 C Street, Bakersfield.

Meeting, *Third Thursday, 8:00 p. m.*

Kings County Medical Society

President, P. K. Edmunds, Corcoran.

Secretary, William A. Johnstone, Hanford.

Meeting, *Second Monday, 8 p. m., Legion Hall, Hanford.*

Lassen-Plumas-Modoc County Medical Society

President, C. I. Burnett, Susanville.

Secretary, Fred J. Davis, Jr., Westwood.

Meeting, *On Call.*

Los Angeles County Medical Association
1925 Wilshire Boulevard, Los Angeles

President, William H. Daniel, 1930 Wilshire Boulevard, Los Angeles.

Secretary, George D. Maner, 1925 Wilshire Boulevard, Los Angeles.

Meetings, *First and Third Thursdays, 1925 Wilshire Boulevard, Los Angeles.*

Marin County Medical Society

President, Harry N. Hensler, Home Market Building, San Anselmo.

Secretary, Carl W. Clark, 510 B Street, San Rafael.

Meeting, *Fourth Thursday, 7:00 p. m., Marin Golf and Country Club.*

Mendocino-Lake County Medical Society

President, Robert B. Smalley, Willits.

Secretary, Dallas Wagner, Fort Bragg.

Meeting, *On Call.*

Merced County Medical Society

President, E. M. Soderstrom, Merced.

Secretary, Fred O. Lien, Shaffer Building, Merced.

Meeting, *Third Thursday, Hotel Tioga, Merced.*

Monterey County Medical Society

President, Walter P. Farr, 308 Main Street, Salinas.

Secretary, Herbert Archibald, Salinas National Bank Building, Salinas.

Meeting, *First Thursday.*

Napa County Medical Society

President, Alexander H. McLeish, Veterans Home Hospital, Yountville.

Secretary, M. M. Booth, Bruck Building, St. Helena.

Meeting, *First Wednesday.*

Orange County Medical Society

President, M. W. Hollingsworth, 1806 No. Main Street, Santa Ana.

Secretary, Glenn Curtis, 323 So. Pom Street, Brea.

Meeting, *First Tuesday, 8 p. m., Chapel of the Orange County Hospital Orange.*

Placer County Medical Society

President, William M. Miller, Auburn.

Secretary, Robert A. Peers, Colfax.

Meeting, *At Call of President.*

Riverside County Medical Society

President, N. K. Bear, 3655 Fourteenth Street, Riverside.

Secretary, Thomas A. Card, 3616 Main Street, Riverside.

Meeting, *Second Monday, 8 p. m., Library, Riverside Community Hospital.*

Sacramento Society for Medical Improvement

President, Manuel Azevedo, 1027 Tenth Street, Sacramento.

Secretary, Glenn E. Millar, 321 Physicians Building, Sacramento.

Meeting, *Third Tuesday, 8:30 p. m., Auditorium, Sacramento.*

San Benito County Medical Society

President, J. M. O'Donnell, Hollister.

Secretary, L. E. Smith, Hollister.

Meeting, *At Call of President.*

San Bernardino County Medical Society

President, Delbert B. Williams, 1151 D Street, San Bernardino.

Secretary, A. E. Varden, Medico-Dental Building, San Bernardino.

Meeting, *First Tuesday, 8 p. m., San Bernardino County Charity Hospital.*

San Diego County Medical Society
Fourteenth Floor, Medico-Dental Building, 233 A Street, San Diego

President, Hall G Holder, 1109 Medico-Dental Building, San Diego.

Secretary, C. V. Bernardini, Medico-Dental Building, 233 A Street, San Diego.

Meeting, *Second Tuesday, El Cortez Hotel.*

San Francisco County Medical Society
2180 Washington Street, San Francisco

President, Edwin L. Bruck, 384 Post Street, San Francisco.

Secretary, Stanley H. Mentzer, 2180 Washington Street, San Francisco.

Meetings, *Every Tuesday, 8:15 p. m., 2180 Washington Street, San Francisco.*

San Joaquin County Medical Society

President, N. P. Johnson, Medico-Dental Building, Stockton.

Secretary, George H. Rohrbacher, Medico-Dental Building, Stockton.

Meeting, *First Thursday, 8:15 p. m., Medico-Dental Club Rooms, Stockton.*

San Luis Obispo County Medical Society

President, J. B. V. Butler, 722 Marsh Street, San Luis Obispo.

Secretary, E. M. Bingham, County Health Department, San Luis Obispo.

Meeting, *Third Saturday, 6:30 p. m., Gold Dragon Cafe, San Luis Obispo.*

(Roster lists continued on advertising page 6)

San Mateo County Medical Society

President, N. D. Morrison, 205 Third Avenue, San Mateo.

Secretary, J. Garwood Bridgman, 205 Third Avenue, San Mateo.

Meeting, *Fourth Wednesday, Benjamin Franklin Hotel, San Mateo.*

Santa Barbara County Medical Society

President, W. H. Johnston, 1515 State Street, Santa Barbara.

Secretary, D. H. McNamara, 317 W. Pueblo Street, Santa Barbara.

Meeting, *Second Monday, Cottage Hospital.*

Santa Clara County Medical Society

President, Cletus S. Sullivan, Bank of America Building, San Jose.

Secretary, Leslie B. Magoon, 652 East Santa Clara Street, San Jose.

Meeting, *Third Wednesday, 8 p. m., Medico-Dental Building, San Jose.*

Santa Cruz County Medical Society

President, John T. Harrington, 10 Cooper Street, Santa Cruz.

Secretary, Samuel B. Randall, 84 Walnut Avenue, Santa Cruz.

Meeting, *First Monday, 7:30 p. m., Club Rio del Mar, Aptos.*

Shasta County Medical Society

President, B. F. Saylor, Redding.

Secretary, Morton J. Murphy, 1542 Market Street, Redding.

Meeting, *Second Monday.*

Siskiyou County Medical Society

President, J. B. McGuire, Mt. Shasta.

Secretary, Victor W. Hart, 113 No. Oregon Street, Yreka.

Meeting, *Sunday on call.*

Solano County Medical Society

President, Ream S. Leachman, 727 Sonoma Street, Vallejo.

Secretary, John W. Green, Box 539, Vallejo.

Meeting, *Second Tuesday, 8 p. m., Casa de Vallejo Hotel, Vallejo.*

Sonoma County Medical Society

President, D. C. Oakleaf, 301A West Street, Healdsburg.

Secretary, T. E. Albers, 600 B Street, Santa Rosa.

Meeting, *Second Thursday.*

Stanislaus County Medical Society

President, John A. Cooper, 1024 J Street, Modesto.

Secretary, Hoyt R. Gant, 403 Beaty Building, Modesto.

Meeting, *Second Friday, 7:30 p. m., Hotel Hughson.*

Tehama County Medical Society

President, O. T. Wood, Red Bluff.

Secretary, R. G. Frey, Red Bluff.

Meeting, *At Call of President.*

Tulare County Medical Society

President, Newton Miller, 231 No. Main Street, Porterville.

Secretary, Ray Cronemiller, Exeter.

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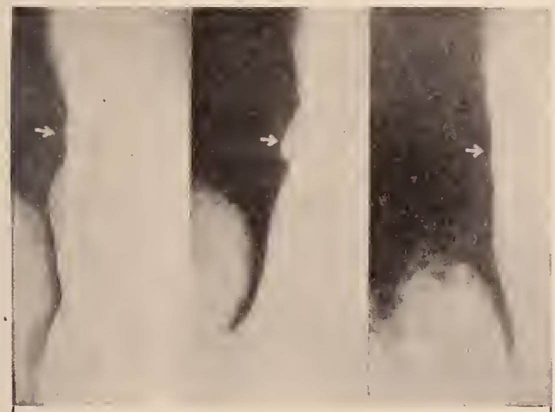

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*Windwer and Matzner, *Am. Jl. Dig. Dis.* 5:743, 1939.

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Place of Sulfanilamide in Pneumonia Treatment Not Yet Established.—The future specific treatment of pneumonia probably will be with a combination of sulfanilamide and pneumococcus serum, especially in those cases caused by types II and III pneumococci, Alvin E. Price, M. D., and Gordon B. Myers, M. D., Detroit, state in *The Journal of the American Medical Association* for March 18.

Although the results obtained from using the drug in the treatment of pneumonia are encouraging, the two men point out, the place of sulfanilamide in the treatment of the disease is not yet definitely established.

Their paper in *The Journal* is a preliminary report, based on 115 cases of pneumococcic pneumonia treated with uniform doses of sulfanilamide, forty cases with Felton serum and ninety-four controls with no specific treatment.

The death rate was 15.7 per cent for the group of patients treated with sulfanilamide and 30.8 per cent for the controls. The death rate for fifty-seven patients with types I, II, V, VII and VIII pneumonia treated with sulfanilamide was 10.5 per cent, whereas it was 27.5 per cent for the forty patients with the same types of pneumonia treated with serum.

Of twenty-one patients with pneumococci in the blood stream treated with sulfanilamide seven died, of twelve treated with serum six died and of fifteen controls thirteen died.

Some adverse reactions due to sulfanilamide treatment occurred. In 5.2 per cent of the patients treated with sulfanilamide a severe anemia developed and in an additional 18.2 per cent moderate secondary anemia, influenced by the infection, developed.

Death Rate of Pneumonia with Pregnancy Is Higher. Pneumonia complicated by pregnancy has a much higher death rate than it does in nonpregnant women, Maxwell Finland, M. D., and Thomas D. Dublin, M. D., Boston, point out in *The Journal of the American Medical Association* for March 18. It accounts for about one death in every 5,000 deliveries and is the cause of about one-half of the maternal deaths not directly due to pregnancy.

Doctors Finland and Dublin studied the incidence of pneumonia in pregnancy at the Boston City Hospital. About one of every eight women of child-bearing age who had pneumonia was pregnant, 0.63 per cent of all women admitted during pregnancy or for delivery had pneumonia and in 1.2 per cent of all the cases of pneumonia the condition was complicated by pregnancy.

A study of 212 cases of pneumonia complicating pregnancy in which the type of organism causing the infection was determined, revealed that the incidence of pneumococcic types was similar to that found in all cases of pneumonia in adults. The authors state that "the types for which specific antipneumococcus serum has proved effective were the most frequent.

"Blood borne infection was more frequent in pregnancy than in all cases for the same age groups. Likewise the death rates were higher than in corresponding cases for the same age group.

"The death rates were highest for late pregnancy and for women whose pregnancy was terminated during the disease.

"The death rate for all the serum treated patients was almost one-half of that for the corresponding nonserum treated patients. The lower death rates were for pneumonia complicating both early and late pregnancy, for pneumonia after delivery, and for those women whose pregnancy was unaffected.

"The frequency with which pregnancy was terminated did not seem to be influenced by serum treatment.

"The pneumonias of pregnancy are sufficiently serious to warrant the use of every available means of treatment, and the proved efficacy of specific serum treatment warrants primary consideration in those cases in which it is applicable."

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Widespread Use of Tuberculin Test Urged to Discover Infection.—Emphasizing the importance of early diagnosis in a tuberculosis control program, E. A. Thacker, M.D., Urbana, Illinois, in *Hygeia,* the health magazine, for April, urges the widespread use of the tuberculin test to discover infection.

"Early tuberculosis ordinarily manifests itself in an insidious, gradual onset, sapping the vitality and strength of the individual, yet producing only vague, indefinite symptoms," the author says. "A hacking cough often attributed to smoking or fatigue attributed to overwork may be all that is noticed."

Many persons, therefore, fail to go to a physician when such symptoms occur. A routine program using the tuberculin test, such as many communities and schools have inaugurated, discovers such early cases.

While a positive reaction to the tuberculin test does not mean that the person examined has active tuberculosis, it indicates that at some time or other he has been infected with it. "Positive reactors are far more likely to develop the disease in later life than are the negative reactors," Doctor Thacker points out. Therefore, an x-ray examination should be performed on all positive reactors to determine whether the disease is in the active stage.

Discussing the course of the disease, the author says, "The initial or childhood type of infection produces an inflammatory or pneumonia-like lesion in the lungs and after weeks or months usually completely heals, leaving a small scar or a calcified nodular tubercle. Although children may die from this first infection, the vast majority overcome it, and many pass through this initial infection without knowing it.

"The adult type of tuberculosis occurs in one of two ways. The small healed lesions from the initial infection may break down, allowing some of the organisms that have remained alive within the tubercle to spread through the allergic tissues. Or else the person comes in contact with an active case of tuberculosis; the bacilli are taken into the lungs and the destructive type of tuberculosis begins.

"The classic symptoms of the reinfective or adult type of pulmonary tuberculosis include loss of appetite, loss of weight, fatigue, unexplained pains in the chest, afternoon fever, pleurisy, cough and sometimes blood in the sputum.

At birth an individual has certain definite possibilities for physical and mental progression depending on the health of his parents and the hereditary potentialities coming from his ancestors.—*Hygeia.*

Christmas is a blending of two ancient traditions—an austere ecclesiastical tradition and a pagan tradition of feasting which was anything but austere.—*Hygeia.*

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Estimate 48,000,000 Cases of Trichinosis in the United States.—The recent evidence from autopsies that 36 per cent of the inhabitants of Cleveland have trichinosis must not be interpreted as proof that that city is the most highly infested area in the United States, *The Journal of the American Medical Association* for March 18 says.

Such evidence suggests rather that the routine diagnostic methods employed by earlier investigators are fallacious, *The Journal* points out. Routine examinations of the diaphragms of adult cadavers by the Baermann digestion method has led previous investigators to the conclusion that approximately 13.67 per cent of all persons in or around Washington, D. C., are infested with trichinae, 17.5 per cent in Minneapolis and Rochester, N. Y., 24 per cent in San Francisco and 27.6 per cent in Boston.

The editorial states that C. H. Evans, M. D., of the Institute of Pathology, Cleveland, supplemented this routine diagnostic method by application of a newer technic. Combining all positive data, Evans found thirty-six positive cases of trichinosis in the first hundred Cleveland autopsies studied by his double technic.

"Applying the implied correction coefficient to the percentages previously reported from other cities," the editorial says, "one would conclude that there are presumably the following percentages of trichina infestation in other American cities: Washington, D. C., 24.6 per cent, Minneapolis and Rochester, N. Y., 31.5 per cent, San Francisco 43 per cent and Boston 49.7 per cent, an average of 37 per cent infestation of the urban population of the United States.

"There is no way, of course, of estimating the resulting social or economic loss; but the estimated 48,000,000 cases of trichinosis in the United States are far from being a national asset."

Take care of your health; you have no right to neglect it, and thus become a burden to yourself, and perhaps to others. Let your food be simple; never eat too much; take exercise enough; be systematic in all things.—W. Hall.

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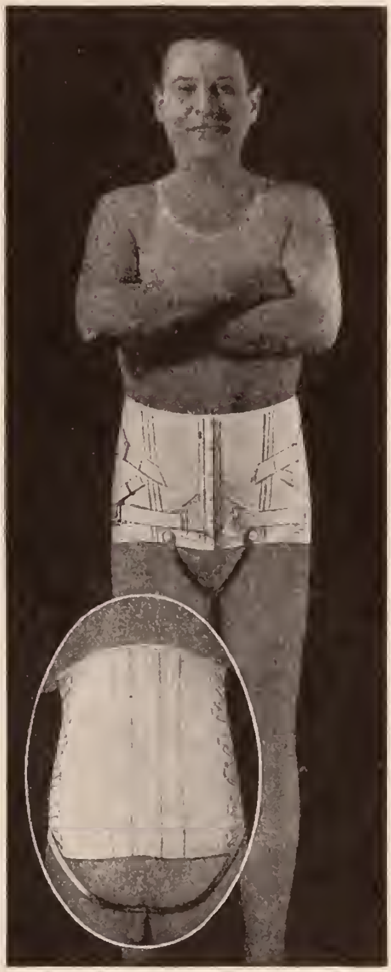

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Excess Weight Increases Mortality.—Because excess weight leads to crippled functioning of several essential organs of the body, fat people neither feel as well nor live as long as slender people or those of average weight, Lemuel C. McGee, M.D., Elkins, West Virginia, says in *Hygeia,* the health magazine, for May.

"The actuality of a shorter life is well established from careful studies," Doctor McGee points out. "The Actuarial Society of America has found that at age 55, 20 per cent overweight means 20 per cent higher mortality and 40 per cent overweight brings 65 per cent higher mortality.

"In long standing obesity there is an infiltration of fat into most of the body organs, particularly into the heart and blood vessels. In both of these places, the fat seriously hinders a vital function. For this reason the death rate from circulatory disease is two and a half times as great in people overweight as in people with normal weight.

"Many of these needless deaths are associated with high blood pressure, for this degeneration becomes more dangerous under the strain created by the fat."

Excess fat is considered by one authority to be the most important single cause of diabetes. Fat people are unduly susceptible to diseases of the liver and gallbladder, they suffer excessively from heat and they are less resistant to bacterial infections than others. The risk of a major operation to the life of a fat man is alarming.

The bony skeleton of the human body suffers from overload it must bear in the corpulent man or woman. The arches of the feet give way to chronic flatfoot. The joints of the spine develop worn areas with a secondary growth of spurs of bone, and arthritis results.

Although in rare instances overweight may be attributed to glandular dysfunction, the cause in the vast majority of cases is simply overeating, the author says. For most of us, eating is a habit and appetite is not an expression of the actual need of the body for food but rather a cultivated response of the highly complicated nervous system of man.

"The problem of weight reduction is actually a scientific and mathematical one," Doctor McGee declares. "The caloric values of foods can be determined from many sources. The kind and amount of food to be taken can be calculated by simple addition."

Live with those from whom you can learn; let friendly intercourse be a school for knowledge, and social contact, a school for culture; to make teachers of your friends is to join the need of learning to the joy of converse. Happiness among the understanding is mutual, rewarded for what they say by the approval they receive; and for what they hear, by what they learn; ordinarily it is personal interest that draws men together but here it is glorified. A man of understanding seeks out the houses of those true noblemen which are more the stages of an heroic than the palaces of vanity. There exist men in this world, known to the discerning, who in their bearing are veritable exemplars of every greatness and whose train, even constitutes a courtly academy of art and of learning.—Baltazar Gracian, 1653.

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BOOKS RECEIVED

Cutaneous Cancer and Precancer. A Practical Monograph. By George M. Mackee, M. D., Professor of Clinical Dermatology and Syphilology and Director of Skin and Cancer Unit, New York Postgraduate Medical School and Hospital, Columbia University, and Anthony C. Cipollaro, M. D., Associate in Dermatology, Skin and Cancer Unit, New York Postgraduate Medical School and Hospital, Columbia University. Cloth. Pp. 222, with a foreword by Francis Carter Wood, M. D., and 245 illustrations. Price, $3.75. New York: The American Journal of Cancer, 1937.

Gross Anatomy. A Brief Systematic Presentation of the Macroscopic Structure of the Human Body. By A. Brazier Howell, Associate Professor of Anatomy, Johns Hopkins University School of Medicine. Colth. Pp. 403, illustrated. Price, $6.00. New York: D. Appleton-Century Company, Incorporated, 1939.

Practical Dermatology and Syphilis. By Harry M. Robinson, M. D., Professor of Dermatology, and Director of the Syphilis Clinic, University of Maryland School of Medicine; Instructor in Medicine, Syphilis Division, Johns Hopkins Medical School. Cloth. Pp. 397, with illustrations. Price, $4.50. Philadelphia: P. Blakiston's Son & Co., 1939.

English, German, French, Italian, Spanish Medical Vocabulary and Phrases. By Joseph S. F. Marie. Foreword by Chevalier Jackson, M. D., Sc. D., LL. D., F. A. C. S., Honorary Professor of Broncho-Esophagology and Consultant in Broncho-Esophagologic Research, Temple University School of Medicine, Philadelphia. Cloth. Pp. 358. Price, $3.00. Philadelphia: P. Blakiston's Son & Co., Inc., 1939.

The Mechanism of Thought, Imagery, and Hallucination. By Joshua Rosett, Professor of Neurology in Columbia University, Scientific Director, Brain Research Foundation, Inc., New York. Cloth. Pp. 289. Price, $3.00. New York: Columbia University Press, 1939.

Clinical Gastroenterology. By Horace Wendell Soper, M. D., F. A. C. P., St. Louis, Missouri. Cloth. Pp. 314, with 212 illustrations. Price, $6.00. St. Louis: The C. V. Mosby Company, 1939.

The Vaginal Diaphragm. Its Fitting and Use in Contraceptive Technique. By LeMon Clark, M. S., M. D., Chicago. Author of "Sex Education" and "Emotional Adjustment in Marriage." Cloth. Pp. 107, illustrated. Price, $2.00. St. Louis: The C. V. Mosby Company, 1939.

Annual Report of the President of Stanford University. For the Forty-seventh Academic Year, ending August 31, 1938. This being the thirty-fifth report submitted, to which are appended annual reports of the comptroller, departments, committees, and publications of the faculty. Paper. Pp. 575. Stanford University: Stanford University Press, 1938.

Medical Leaves, 1939. Editor in Chief, Dr. Abraham Levinson; Managing Editor, Dr. Hershel Meyer; Associate Editors, Dr. Irwin Rubell, Dr. Jeanette Hork, Dr. Maurice I. Kaplan, and Samuel H. Holland. Cloth. Pp. 196. Price, $3.00. Chicago: Medical Leaves, Inc., 1939.

How to Open a New Book.—Stand the book, back downward, on a table or smooth surface. Press the front cover down until it touches the table, then the back cover, holding the leaves in one hand while you open a few of the leaves at the back, then at the front, alternately pressing them down gently until you reach the center of the volume. This should be done two or three times. Never open a book violently nor bend back the covers. It is likely not only to break the back but also to loosen the leaves.

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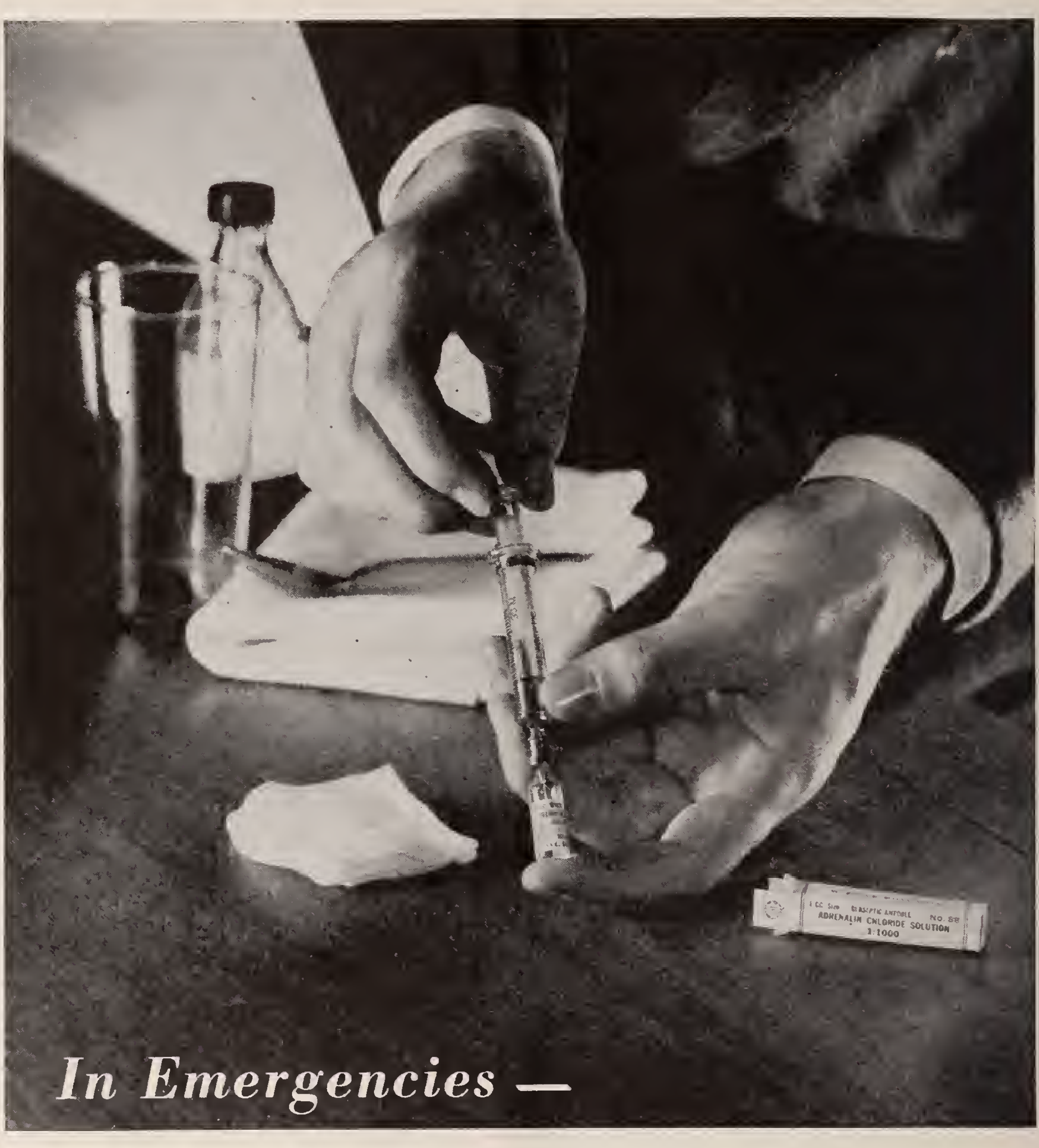

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TWENTY-FIVE YEARS AGO

(Continued from Text Page 392)

The Annual Meeting at Santa Barbara—It is not possible to publish the full proceedings of the annual meeting held last month at Santa Barbara in this issue of the Journal without causing too long a delay in getting it out; they will appear in the June number, however, and as matters of the greatest importance were considered and acted upon, the reports should be read by every member. During January, February, and March, a number of conferences were held between representative members of the Society, the Insurance Commission, and the Board of Adjusters of the insurance companies; and the result of these conferences, in the form of a general agreement and fee schedule, was presented to the House of Delegates in the report of the Council. The agreement is practically a condensation and crystallization of the suggestions which have been made editorially in the Journal during the past four months. . . .

From an Original Article on "George Chismore," by Douglass W. Montgomery, M. D., San Francisco.—I first met George Chismore in the spring of 1886, shortly after I began to practice in San Francisco. Like every beginner in a strange city, I felt the need of friends, and Chismore had a face attractive to everyone seeking human sympathy. This chance acquaintance would, however, never have amounted to anything if it had not been for favoring circumstances. Harry M. Sherman was then living with Chismore, and Sherman and I became fast friends. We two determined to agitate the forming of a society composed of men of our own age, and so began the Friday Evening Club, that met on Friday evenings and that had neither constitution, by-laws nor a permanent place of meeting, as we met in the residence or office of the members. The club was comprised of:

George Chismore, Alexander P. Whitell, William S. Whitwell, John F. Morse, Henry Ferrer, Martin Regensburger, Harry M. Sherman, Robert I. Bowie, J. D. Arnold, W. W. Kerr, C. A. Von Hoffmann, and myself. It was out of this association that the San Francisco Polyclinic later evolved. . . .

He was often not at all enchanted by an accurate diagnosis, and this led to the following amusing incident:

While Chismore was off on a hunting trip, Sherman called me in to see a patient who had arrived from the country to consult Chismore. I made a diagnosis of leukocythemia, of which I was very proud, seeing that shortly before one of these cases had slipped through my hands. We gave the family and the patient the usual gloomy prognosis. Shortly afterward Chismore returned and gave us an entirely new view of the case. According to him we had disturbed the family, and had caused a great deal of unnecessary trouble, and had not done anything to relieve the discomfort of the patient. In fact we had added to the patient's discomfort. It is needless to say that I then learned a few things, both about patients and physicians, and their mutual relations.

He suffered from many disadvantages from his lack of training, although in some ways it may have been an advantage. An educated man, unless he keeps a strict guard on his manner of observing natural phenomena, may become hedged in by his training to think along unbending lines. Books must necessarily be schematic as they have to be built within rigid limits, otherwise they would be compilations of disorder, an inextricable tangle of actions and facts. To comprehend disease phenomena according to books would be to regard them as solid cubes and parallelo-

(Continued on Next Page)

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TWENTY-FIVE YEARS AGO

(Continued from Preceding Page)

grams, sharply limited and wholly enclosed. To unswervingly follow their guidance is, therefore, to become a ritualist rather than a thinker. Chismore was far from being so constituted. He would see as many penumbrae, shadings, and rotundities in nature as Leonardo da Vinci himself. . . .

Not long before he took to his deathbed I met Chismore on Sutter Street, and a kindlier, more benevolent face you would rarely see. He was thinner than he had been, and his white hair and beard, with his delicately traced features, gave him an ethereal, spiritual look. Some time after this I went to visit him with Sherman. On entering the room Sherman kissed the old man on the forehead. The answering look of full, tender, lingering affection was one of the finest sights I have ever seen.

Hardship may embitter a man, and prosperity is even a severer test for human character, and Chismore had passed through all grades of both the one and the other, and at the end still retained his capacity for loving and being loved. This was worth while.

From an Original Article on "A Review of the Early Vaccination Controversy with an Original Letter by Jenner Referring to It, and to the Spread of Vaccination to the Spanish Possessions of America, the Philippines, and Other European Settlements in the Orient," by Philip King Brown, M.D., San Francisco.—No sooner had Edward Jenner proposed the practice of vaccination as a preventive for smallpox than there arose in England a controversy as to its safety and efficiency which has been endemic ever since, interrupted by more or less violent epidemic outbreaks. Nor has the controversy been confined to the home of its birth, for we find it more than a century later in full flower even in the classic hamlets of our own state.

The humor of the situation reveals itself in the analysis of the present state of the controversy, in which it is clear that the antivaccinationists have contributed no new argument in those more than hundred intervening years, whereas science has shown that whatever little claim they had to a hearing was based on misrepresentations now well understood and revealing no truth in favor of their contention. The tenth edition of the Encyclopedia Brittanica, in an article on vaccination, presents only an unintelligent arraignment of the method unworthy of a place even in the earliest edition. In a short biography of Jenner, closing with an apologetic paragraph, is the only meager account of Jenner's great discovery. The eleventh edition gives a fairly satisfactory historical review of the established facts of vaccination. . . .

From an Original Article on "Reminiscences: The Transition of Surgery to Antiseptic Surgery," by Martin Regensburger, M.D., San Francisco.—In the early months of 1875 I had the extreme pleasure of being a witness to one of the most marvelous reactions in surgery.

At the Allgemeine Krankenhaus in Munich, Von Nussbaum, professor of surgery at the University of Munich, one day, in utter disgust, threw down his knife with the expression that he would never operate another case in that hospital. Every case he operated was infected with nosocomial (hospital) gangrene. Every wound that came into the hospital, even the slightest lesion, such as a panaritium, would become infected. The mode of procedure in the operating room at this time was as follows:

The nurse would bring into the operating room a tinker's soldering pot, and we students would take the soldering

(Continued on Page 18)

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Proc. Soc. Exp. Biol. and Med., 1934, 32, 241-245 ☐
Laryngoscope, 1935, XLV, 149-154 ☐
N. Y. State Jour. Med. 1935, 35-No. 11, 590 ☐
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TWENTY-FIVE YEARS AGO

(Continued from Page 16)

iron and sear the infected wounds, reminding us of the days of Ambrose Paré. For the benefit of those who have not seen hospital gangrene (I, myself, not having seen it for the last thirty-five years), I would state that it was one of the most common complications of wounds, and its history was marked by a fearful mortality; and so inseparable was the disease once assumed to be from hospitals that Poteau (1783), the first historian of the disease, himself a sufferer from it, proposed the inquiry whether, in view of the facts, "hospitals were not more pernicious than useful to humanity." . . .

Lister's achievements were just in embryo at that time and but little was known about antiseptic surgery; there were many pros and cons. Such men as Billroth bitterly opposed the whole technique of Lister's, saying that it was not the technique, but that simple cleanliness and hot water would accomplish the same results.

Pasteur's theories at that time were also in their infancy. The general theory was that there was only one source of contamination and that was the air. Upon this theory Lister based his ideas and thought by keeping the air, and especially unclean air, from wounds he would prevent infection, etc.

Von Nussbaum determined to send his first assistant, Von Lindpaintner, to Edinburgh for the purpose of studying Listerism. In about two months he returned to Munich with all of the paraphernalia of Listerism: carbolated gauze, mackintosh (a waterproof rubber sheet), protective (a greenish oilsilk or linen), drainage tubes and catgut ligatures, and last, but not least, a steam spray.

Before the operation the steam spray was set to work and the air was thoroughly saturated with carbolic acid (mind you, no gowns, no thorough cleaning nor disinfecting of the hands, etc.), then the patient was brought in and the spray was played over the field to be operated upon, and kept up to the end of the operation. Many times the operator would have to stop for the reason that his hands became absolutely anesthetic from the carbolic spray. The sutures were either catgut or silver wire; then the spray was taken away and the protective was placed directly over the wound, then eight layers of gauze, then the mackintosh, and then the gauze bandage. The results were simply marvelous. If the technique was properly carried out, all wounds, excepting those near or in connection with the mucous membrane, healed by first intention. It was marvelous to see the change in that hospital.

I remember Von Nussbaum operated upon a patient in a bathtub for loose cartilages in the knee joint, under water, for fear the air might infect the wound; it did not seem to matter what condition the water was in. Under Listerism I saw the same operation with splendid results.

About six months after Listerism was introduced into Munich, Von Nussbaum invited Lister to Munich and introduced him to the students at the clinic, and this is where I first met Lister, the most modest man that I have

(Continued on Page 20)

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TWENTY-FIVE YEARS AGO

(Continued from Page 18)

ever met—a man about six feet tall and extremely bashful; while he was being eulogized before the students his lips would twitch from embarrassment. After Nussbaum had praised him up to the skies, calling him a second Saviour, Nussbaum fell upon his neck and kissed him, and his embarrassment and modesty were really painful to observe—the great man almost collapsed. . . .

When I came back to San Francisco I brought all of the material necessary to carry out Listerism, and introduced it into the City and County Hospital under Douglass, Professor of Surgery in the Medical College of the Pacific, and later the Cooper College.

Douglass was an excellent surgeon, but very slow to introduce innovations, and in using the spray he would exclaim, "Take that damn thing away"; then I would say it was part of the technique and he would be satisfied for a few minutes and again would say, "Take it away." His hands would become numb during the operation and he would have to stop for a few minutes, but his results were fine.

From an Original Article on "The Green Operating Room at St. Luke's Hospital," by Harry M. Sherman, M. D., San Francisco.—The difficulty I have had in seeing into the mouth of a small child, to properly trim and suture the soft palate and uvula, in cases of cleft palate, led me, some ten years ago, to use black cloths around the mouth instead of the ordinary white toweling. With the white environment, the hollow of the mouth is in the deepest shadow and cannot be comfortably seen, unless it be specially and overilluminated, as by the wearing of a headlight by the operator. With the black environment, however, the mouth is in the high light, not in the shadow, the pupils of the operator are not dominated by the light reflected from the white towels, and ordinarily bright daylight is ample illumination for the work in the back of the mouth.

The discomfort I have had in the present-day white operating rooms led me to suggest that we have dark floors and wainscots in these rooms, so that the operator who looks up from a wound shall not encounter a glare of light and find his eyes useless for a moment, as he looks back into the less well-illuminated wound. The color scheme, it seemed to me, should start from the red of the blood and of the tissues; therefore, I advised that green, the complementary color to red, should be chosen for the color of the floor and wainscot. The particular shade of green to be selected was that which was complementary to hemoglobin, and it was found to be the green of the spinach leaf. Incidentally, it may be said that the iron in the chlorophyl of spinach is said to be in the same chemical combination as is the iron in hemoglobin, but I know nothing of the value of this, in making spinach-green complementary to hemoglobin red.

A room painted in this way—the floor and the walls for six feet from the floor—a bright spinach green, and all above a glazed white, was matched for use against a room painted a glazed white—floor, walls, and ceilings—in the little operating pavilion built at St. Luke's Hospital just after the fire. No one who could get into the green room to do an operation ever went into the white room; and after some months of this experience the point was accepted as settled sufficiently to warrant the innovation of a room similarly colored in the operating suite in the new hospital. . . .

From an Original Article on "Blindness Following Injuries to the Back of the Head," by L. Newmark, M. D., San Francisco.—Given a patient who has sustained an in-

(Continued on Page 22)

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TWENTY-FIVE YEARS AGO

(Continued from Page 20)

jury to the back of his head, and is found to be deprived of his power of vision without showing any ocular changes, the physician will find in the following observations what he may expect in regard to the restoration of sight. . . .

From an Original Article on "Removal of the Cervical Glands in Malignant Disease of the Head and Face," by H. A. L. Ryfkogel, M. D., San Francisco.—No operation for removal of cancers of the head and face can offer any hope of permanent cure, in the majority of cases, unless the lymph glands that drain the affected area (and, as far as possible, the intervening lymphatics) are thoroughly removed. The gland-bearing tissues and, if feasible, the original growth, should be removed in one mass so as to avoid cutting or crushing the cancerous material and implanting or forcing cancer cells into the healthy tissues. . . .

From an Original Article on "Recollections of the Listerian Epoch," by Charles G. Levison, M. D., San Francisco.—The subject that I have chosen for my paper this evening is of perennial interest, for it has exercised an incalculable influence upon the evolution of modern medicine. The name of Lister is so well known to the fraternity that it needs no introduction, but, unfortunately, this is not the case with the layman, who is quite uninformed regarding the remarkable achievements that have been accomplished in medicine, and it would seem an almost hopeless task to properly educate him. In this connection I have often, in conversation, inquired of people whether the name of Lister was known to them, and the response has almost invariably been returned: "Oh, yes; he is the man that makes the Listerine." I repeated this to Sir Charles Ball when he was here delivering the Lane lectures a number of years ago, and he was very much amused. He laughed heartily and said that he was going to tell Sir Joe about it. At that time Lord Lister had not yet been elevated to the peerage, which event took place in 1897, and it was the first time that any medical man had been so honored.

I have been particularly interested in Lister as a man, as I had the privilege of knowing him personally. It was in the summer of 1892 while he was still teaching surgery in Kings College, London. One year later he retired from active work.

I visited him as a student and was received most graciously, and during several times that I saw him he addressed his remarks particularly to me instead of to the students. He took me through the wards and he removed the dressings from the patients to demonstrate the action

(Continued on Page 24)

In Appreciation

As an expression of appreciation to the medical profession of the Western States, the Schering Corporation is pleased to sponsor the exhibit on "SEX HORMONES" in the Hall of Science of the Golden Gate International Exposition, in San Francisco.

The role of hormones in controlling the physical and mental development, and the sexual function of men and women is concisely told. That you, the doctor are prepared to treat endocrine disorders is pointed out. The exhibit is purely educational, non-commercial. We hope you will visit it.

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TWENTY-FIVE YEARS AGO

(Continued from Page 22)

of the cyanide of mercury gauze that he had introduced into surgery a short time before. His modesty and simplicity were extreme, and one would never have recognized him as one of the most important influences of all time. An example of his great modesty was shown at an International Medical Congress at which both he and Pasteur were present. In an address that he delivered, he stated that Pasteur was the only one that deserved any credit for the discoveries that he (Lister) had made. . . .

From an Original Article on "Basic Principles in Eczema," by Ernest Dwight Chipman, M. D., San Francisco.—Eczema was defined by Bateman one hundred years ago as "a noncontagious eruption, generally the effect of an irritant, whether externally or internally applied, but occasionally produced by a great variety of irritants in persons whose skin is constitutionally very irritable." It has been said that this definition cannot be improved upon today.

Since Bateman three important doctrines have claimed supremacy. First, Hebra and the Vienna school contended strongly that eczema is of external origin. Following upon this came the French school with the claim that it is of internal or diathesic origin. Later Unna promulgated the theory that all eczemas can be traced to a microbic origin. Both the Vienna and French schools attracted many followers, but Unna's claims never gained wide acceptation. In recent years the most commonly held views have been that eczema is exactly what Bateman called it a century ago, viz., "the effect of an irritant whether externally or internally applied." There has now appeared a tendency toward the idea of exclusively external causation. To what extent this view is tenable a consideration of some of the basic principles of the affection will possibly help us to decide.

No discussion of eczema can be intelligently pursued until there is a common understanding as to the distinction between eczema and dermatitis. . . .

From an Original Article on "A Case of Extraperitoneal, Intraligamentous Dermoid Cyst and Pregnancy," by Henry J. Kreutzmann, M. D., San Francisco.—In the course of time I have operated a few dermoid cysts of the ovary, also some extraperitoneal, intraligamentous cysts not of ovarian origin. Likewise, I have done ovariotomy in a number of cases during pregnancy; but I have never seen an extraperitoneal intraligamentous dermoid, not during nor outside the gravid state, until quite recently. . . .

From an Original Article on "Artificial Cultivation of the Gonococcus," by Ernst Albrecht Victors, M. D., San Francisco.—Experience in attempting the cultivation and isolation of the gonococcus for bacterial vaccines, and for complement-fixation antigen, has long convinced me that this is attended with considerably more difficulty and disappointment than is usually conceded. Less difficulty is encountered with subcultures when primary inoculations have been successful, provided that suitable environment and pabulum have been maintained. . . .

From an Original Article on "Upon the Early Diagnosis of Renal Tuberculosis by the General Practitioner," by Martin Krotoszyner, M. D., San Francisco.—We are accustomed, of late, to point with justifiable pride to the marvelous progress of the science and art of medicine, by which the diagnosis as well as the treatment of all ailments which human flesh is heir to have been revolutionized. At the bedside, as well as in the laboratory, new methods of

(Continued on Page 26)

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(Continued from Page 24)

examination by means of complicated and delicate instruments and apparatus are in daily use at the hands of specialists, experienced in the interpretation of the results of their investigations. Thus, at the great medical centers, and particularly at the large modern hospitals, a correct diagnosis of the more serious pathological conditions is now only considered feasible through so-called teamwork done in several special departments and aided by various laboratory tests. Gratifying as the results are under this system—as regards the welfare of our patients, as proved by the marked and steadily growing decrease of the mortality rate—matters are, nevertheless, not quite as favorable for the general practitioner who has been brought up under this system at the teaching hospital of his college and who, when left to his own resources, has to make his diagnosis and to devise the proper and effective treatment by a less circuitous, complicated and costly route. For the most important aid toward accomplishing this end, in view, viz., the art of observation, or the faculty to correctly interpret symptoms and to group them to a diagnosis, has not been sufficiently developed by the above-described system. Thus, it occurs that patients daily enter our hospitals with long-standing lesions, the earlier recognition of which would have spared them long suffering and a serious operation, often resulting in the loss of an important organ.

No special field of medicine has of late made more rapid strides as regards exactness of diagnosis and efficacy of treatment than urology. It is generally conceded that these excellent results are obtained through the skillful application of instruments of precision; and the opinion prevails among the rank and file of the profession that a urological lesion cannot be diagnosed without instrumentation. . . .

From "Important Information!" Action of the State Society on Industrial Accident Work.—In these four pages—so numbered that they may be torn out of the JOURNAL, if so desired, without mutilating the remaining reading pages—will be found presented the plan recommended by the Council of the State Society and adopted by the House of Delegates at the Santa Barbara meeting last month, together with the fee schedule which was also presented as a part of the report and adopted.

The full proceedings, minutes, reports. etc., will appear in the June issue.

* * *

Report of the Reference Committee on New Business: . . . Item 22. We recommend for adoption and ratification by the House of Delegates, the recommendations made by the Council relative to accident insurance, and the relation of our members and Society and county units thereto, as given on pages 6 to 7 inclusive, of attached report (beginning on page 6 with the line, "In the following statement," etc., and ending on page 7 with the twenty-first line reading, "subject to discipline," etc.) :

"A. Note. In the following statement the Industrial Commission is considered as one of the companies, for it is doing the same sort of work and on the same basis, and is agreeable to the general conditions as outlined.

"B. *Contracts:* No contracts at flat, fixed fees for all work are to be made, and those now existing are to terminate at the earliest possible date.

"C. *Fee Schedule:* The fee schedule, which has been prepared as heretofore indicated and is herewith presented to you, is recommended for the approval of the Medical Society of the State of California and of its various county units, as a schedule of the minimum fees to be charged for the services indicated in the schedule in the treatment of persons who may be injured as specified in the law. Ad-

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THE DOCTOR IS OF NECESSITY A STUDENT OF LIFE. Each new patient presents a new study, a new problem. Psychology plays an important role in the course of treatment he prescribes. With some patients he must be frank to a point of harshness, with others he must be gentle and coaxing. The nature of the illness and, more particularly, the nature of the patient determine his attitude. He knows from experience the value of bolstering his patient's morale. As a student of psychology he knows that few things are more depressing to a woman than the fear that she is losing her charm, that when she no longer cares how she looks the chances are she has lost touch with a vital interest in life. And because he appreciates the importance of a sensible interest in personal appearance he quite rightly encourages his patients to look their best at all times. FINE COSMETICS appeal to that interest. That is why they deserve to be recommended by doctors who are, after all, greatly concerned with their patient's morale.

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ditional compensation will be allowed in unusual cases for unusual services on proper representation.

"D. *Choice of Physician:* The employer (or the company, if the employer is insured) is to have the right to a free choice of physician and such selections are to be made from lists of names furnished by the insurance companies, these lists of names to be the lists of members of the several county medical societies which collectively compose the Medical Society of the State of California; but no member may be compelled to do the work if he does not wish to. Provided, that in counties where there is no county medical society, or in special cases where the employer may desire to secure the services of some physician who is not a member of his county medical society, he reserves the right to do so; also, provided that in the larger centers the societies are to prepare lists of names of members who are willing to do the work and to arrange so that the services of some of them may be secured at any time by means of a telephone exchange or some other plan by which their whereabouts may at any time be ascertained; and also, provided that the companies are to be permitted to advise their policyholders that certain physicians have in the past done work for them satisfactorily. It is understood that an insurance company may have a regularly appointed medical referee in any given locality.

"E. *Adjustment of Fees:* In case a bill rendered by a member is regarded as excessive by the employer (or company), it shall be submitted to the county medical society for scrutiny and adjustment, and if there be still failure to agree, it may be submitted to the Council of the State Society or to the Industrial Commission.

"F. *County Units and Professional Conduct:* In order to carry out the provisions of this plan, it will be necessary for each county unit to approve the schedule—in so far as it applies to the work indicated, and to persons whose income does not exceed the maximum indicated in the law. Charging in excess of the proper ones, or unduly padding bills by fictitious or unnecessary visits, shall be deemed unprofessional conduct and subject to discipline by suspension or expulsion."

(Adopted)

Respectfully submitted,
G. A. Hare, Fresno
Rene Bine, San Francisco
George H. Kress, Chairman, Los Angeles.
(Adopted as a whole)

From California Industrial Accident Commission "Fee Schedule."—"These fees represent a minimum. Fees higher than schedule will be approved when warranted by extraordinary difficulties encountered by the surgeon.

"Unusual cases and procedures not specified are entitled to same fee as specified procedures of approximately equal magnitude." . . .

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If you are interested in this insurance matter and have suggestions to make, write to the secretary, Doctor Jones.

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From an Original Article on "Concerning Ununited Fractures," by James T. Watkins, M. D., San Francisco.—In this paper I take for my text the following sentence from Joseph Bloodgood's review of surgery in *Progressive Medicine:*

"In my mind the most important contribution of Mr. Arbuthnot Lane is the remark that people should demand better results in recent fractures," and this comment by John B. Murphy: "Twenty-five or thirty years ago we practically never had a case of nonunion of a fracture.

(Continued on Next Page)

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TWENTY-FIVE YEARS AGO

(Continued from Preceding Page)

Today cases of nonunion are so common that I do not know what we are going to do."

Rightly to understand the significance of a pathological condition presupposes a knowledge of the normal histology and normal physiology of the affected tissues. For, after all, pathology is only physiology which has broken the law. . . .

From an Original Article on "Artificial Pneumothorax in Advanced Lung Tuberculosis," by Lewis Sayre Mace, M. D., San Francisco.—During the last few years the operation of artificial pneumothorax as a therapeutic procedure in a certain type of cases of lung tuberculosis has come into general use and its value determined.

Following favorable reports from all operators who have obtained 45 or 50 per cent of recoveries in an otherwise hopeless condition, it is natural that the attention of clinicians should turn to the possible value of lung compression in other stages of the disease than that in which the production of an artificial pneumothorax may be said to be the operation of choice.

Tuberculosis mainly confined to one lung, not too far advanced but advancing under proper treatment, while the opposite lung is fairly free from disease, represent the ideal conditions under which a favorable outcome may be expected from this method of treatment; but only a small percentage of cases correspond to this description. The consideration of other indications for compression (such as very early cases, hemorrhage, and advanced bilateral disease in which delay of its progress or amelioration of its symptoms may be hoped for) is at the present time extremely important. The following series of cases is reported for the reason that they all present the same conditions, viz., advanced bilateral disease with cavities in one lung so situated that constant and wearing cough was the result. . . .

From an Original Article on "Iodin a Specific Germicide in Respiratory Affections" (Preliminary Report), by Sanford Blum, M. D., San Francisco.—Few drugs have so successfully stood the test of time as iodin. Not only does its past record bear evidence to its worth, but the esteem in which it is held at present is evidenced by its unanimous employment in the practice of medicine. It is used not only as an antisyphilitic, but in gynecology, dermatology, internal medicine, pediatrics, surgery, and in every branch of medicine. . . .

From "Society Reports. Sonoma County."—Resolutions passed by the Sonoma County Medical Society, March 12, 1914:

WHEREAS, The State of California has passed an act known as the Boynton Act, whereby it is the intention of the State to provide for the care and treatment of all persons who are engaged in the various industrial pursuits, and who may be injured while so engaged; and

WHEREAS, The State has caused to be formed a commission for the enforcement of said act; and

WHEREAS, Said commission has formulated certain rules and regulations for the application of said act, and has fixed a schedule of fees to be paid for medical and surgical services rendered under said act, which they believe to be as liberal as their present financial condition will justify; and

WHEREAS, Said act was passed for the humane purpose of caring for the unfortunates who are engaged in the

(Continued on Page 30)

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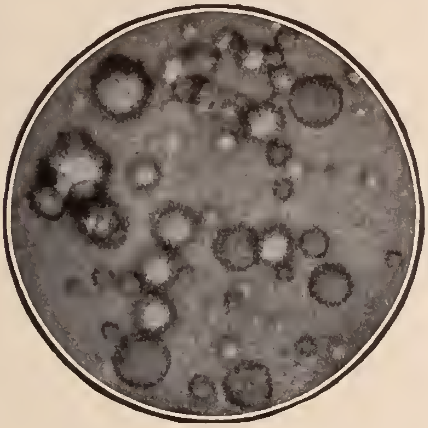

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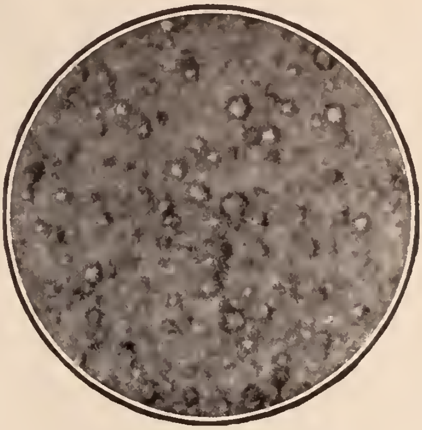

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[1] *Journal AMA 111:703 (August 20, 1938)*

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FORM OF CLAUSE OF WILL PROVIDING FOR CASH BEQUEST

I hereby give and bequeath unto Trustees Of The California Medical Association, a nonprofit corporation of California, the sum of $——— to be known as the ——— Gift, to be used and expended by said corporation for scientific, educational, or hospital purposes.

* * *

FORM OF CLAUSE OF WILL PROVIDING FOR CASH BEQUEST

I give and bequeath unto Trustees Of The California Medical Association, a nonprofit corporation of California, the sum of $———, to be held as a fund, to be known as the [here insert name desired] Fund, the principal whereof shall from time to time be invested to the best advantage compatible with safety, and the income whereof shall be used and applied for scientific, educational, or hospital purposes.

* * *

FORM OF CLAUSE OF WILL PROVIDING FOR BEQUEST OF PERSONAL PROPERTY

I give and bequeath unto Trustees Of The California Medical Association, a nonprofit corporation of California [here describe the property], the same, or the proceeds thereof, to be held as a perpetual fund, to be known as the [here insert name desired] Fund, the income whereof shall be used and applied for scientific, educational, or hospital purposes. The said corporation shall have the power to sell said property and to invest and reinvest the proceeds arising from the sale thereof from time to time as it may deem advisable for the purpose of producing as large an income as may be compatible with safety.

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FORM OF CLAUSE OF WILL PROVIDING FOR DEVISE OF REAL PROPERTY

I give and devise unto Trustees Of The California Medical Association, a nonprofit corporation of California, to aid and further its scientific, educational, and hospital purposes, and to be known as the ——— Gift, the following described real property situate in the County of ———, State of California, and more particularly described as follows, to wit:

* * *

FORM OF CLAUSE OF WILL PROVIDING FOR DEVISE OF REAL PROPERTY

I give and devise unto Trustees Of The California Medical Association, a nonprofit corporation of California [here describe the property], the same, or the proceeds thereof, to be held as a perpetual fund, to be known as the [here insert name desired] Fund, the income whereof shall be used for and applied to the support and maintenance of scientific, educational, or hospital purposes. The said corporation shall have the power to sell said property and to invest and reinvest the proceeds arising from the sale thereof from time to time as it may deem advisable for the purpose of producing as large an income as may be compatible with safety.

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* These Bequest Forms were discussed editorially in CALIFORNIA AND WESTERN MEDICINE, for March, 1936, p. 145, and June, 1936, p. 460.

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TWENTY-FIVE YEARS AGO

(Continued from Page 28)

several industrial pursuits as wage-earners, and whose income is not always adequate to defray the regular household expenses, the education of their children and the misfortunes of sickness, and as conducted by the State is in no way for other than a humane purpose; now, therefore, be it

Resolved, That we, as members of the medical profession of California and of the Sonoma County Medical Society, will assist in carrying out the object of this act by rendering service to any person injured while engaged in the pursuit of his regular duties, and coming under the jurisdiction of this act.

That no member of this society shall enter into any written contract with any insurance company, but shall be eligible to do such work, provided the remittance shall be equal to that paid by the State Insurance Commission.

That it is the opinion of this society that every injured person be free to select his own physician, and we respectfully ask the medical profession of California to use their efforts to have any restriction to the contrary repealed.

S. S. BOGLE W. J. KERR
S. Z. PEOPLES J. W. SCAMELL
W. C. SHIPLEY A. R. HOWARD
J. W. SEAWELL

Committee.

From "Society Reports. Pacific Coast Oto-Ophthalmological Society."—To the Editor of the State Journal:—We would be pleased to have you announce in the next issue of the California State Journal of Medicine the coming meeting of this society in Seattle. July 1, 2, and 3, 1914,

(Continued on Page 34)

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President, California Medical Association
1939

CALIFORNIA
AND
WESTERN MEDICINE

OFFICIAL JOURNAL OF THE CALIFORNIA MEDICAL ASSOCIATION

VOL. 50 MAY, 1939 NO. 5

SALUTATION FROM WILLIAM W. ROBLEE

OF RIVERSIDE

PRESIDENT OF THE CALIFORNIA MEDICAL ASSOCIATION

To Members of the California Medical Association—

Greetings:

It is my happy privilege to extend to you a cordial invitation to attend another annual meeting of your California Medical Association, which will be held May 1 to 4.

This year we return to Del Monte, which choice, we know from past experience, will be a happy one. The hospitality extended by the hotel heretofore has been most cordial; the opportunities for out-of-door sports during the recreation periods are ample, and the provision made for the section meetings is satisfactory. Old friendships will be renewed, new ones acquired, and the social functions are always happy occasions.

Medicine is not static, both its science and art being constantly improved. The doctor of medicine and surgery who fails to take cognizance of new developments soon fails to render the type of service to which his patients are entitled. The papers and discussions arranged by the committee in charge are designed to bring to us, in an authentic and thorough manner, the latest developments of medical science. I urge your attendance at as many sessions as possible.

Consideration will also be given, at the first general session and at the meetings of the House of Delegates, to the present status of our medical economic problems.

There never has been a time in the history of the Association when loyalty to our national, state and county organizations was more necessary. I ask your continued interest and support, in order that those to whom you have intrusted leadership may feel that they are backed by a united profession. A good attendance at the Del Monte meeting will give them that assurance.

Cordially,

W. W. Roblee.

California and Western Medicine

Owned and Published by the
CALIFORNIA MEDICAL ASSOCIATION
Four Fifty Sutter, Room 2004, San Francisco, Phone DOuglas 0062

Address editorial, business and advertising communications to Dr. George H. Kress as per address above.

EDITOR . . . . GEORGE H. KRESS

Advertisements.—The Journal is published on the seventh of the month. Advertising copy must be received not later than the fifteenth of the month preceding issue. Advertising rates will be sent on request.

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Subscription prices, $5 ($6 for foreign countries); single copies, 50 cents.

Volumes begin with the first of January and the first of July. Subscriptions may commence at any time.

Change of Address.—Request for change of address should give both the old and the new address. No change in any address on the mailing list will be made until such change is requested by county secretaries or by the member concerned.

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Contributions—Exclusive Publication.—Articles are accepted for publication on condition that they are contributed solely to this Journal. New copy must be sent to the editorial office not later than the fifteenth day of the month preceding the date of publication.

Contributions—Length of Articles: Extra Costs.—Original articles should not exceed three and one-half pages in length. Authors who wish articles of greater length printed must pay extra costs involved. Illustrations in excess of amount allowed by the Council are also extra.

Leaflet Regarding Rules of Publication.—CALIFORNIA AND WESTERN MEDICINE has prepared a leaflet explaining its rules regarding publication. This leaflet gives suggestions on the preparation of manuscripts and of illustrations. It is suggested that contributors to this Journal write to its office requesting a copy of this leaflet.

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EDITORIALS†

DEL MONTE ANNUAL SESSION: NEWLY-ELECTED OFFICERS

Official Journal in Press During the Annual Session.—CALIFORNIA AND WESTERN MEDICINE's May issue will be in press during the time of the California Medical Association's sixty-eighth annual session at Del Monte, May 1–4. Therefore, in the present number, it will not be possible to give detailed information concerning the proceedings, and a recital of happenings must lie over until June.

Space for the names of newly-elected general officers, however, having been reserved on the last form to go to press, the list received by telegraph from Del Monte may be given.

* * *

Newly-Elected Officers.*—The newly-elected officers include the following:

President-Elect, Harry H. Wilson, Los Angeles.
Speaker, Lowell S. Goin, Los Angeles.
Vice-Speaker, Dewey R. Powell, Stockton.
Councilors: Second District, George D. Maner, Los Angeles; Fifth District, C. Kelly Canelo, San Jose; Eighth District, Frank MacDonald, Sacramento.
Councilors-at-Large: C. O. Tanner, San Diego; J. Elbridge Best, San Francisco; Frederick N. Scatena, Sacramento.
Delegates to the American Medical Association: J. Elbridge Best, San Francisco; Lyell C. Kinney, San Diego; Lowell S. Goin, Los Angeles.
Alternates to the American Medical Association: Robert S. Stone, San Francisco; Bon O. Adams, Riverside; Roy E. Thomas, Los Angeles.

The Hotel Del Coronado at Coronado was announced as the meeting place for the 1940 annual session.

* * *

Service Rendered by Retiring President William W. Roblee and the Incoming President, Charles A. Dukes.—A few words, therefore, about William W. Roblee of Riverside, now past president, and Charles A. Dukes of Oakland, now president, may not be amiss.

As has been stated in the past, positions of responsibility in so large a constituent state medical association as that of California (the fourth largest state unit in the American Medical Association, and perhaps, next year, the third largest) are no longer to be rated as sinecures. Be it said to the credit of the retiring president, William W. Roblee, and to his successor, President Charles A. Dukes

---

† Editorials on subjects of scientific and clinical interest, contributed by members of the California Medical Association, are printed in the Editorial Comment column which follows.

* At the annual organization meeting of the Council, held at Del Monte on Thursday, May 4, 1939, the following officers were elected: Chairman, Dr. Karl Schaupp, San Francisco; Vice-Chairman, Dr. Charles A. Dukes, Oakland. Dr. Earl Moody, Los Angeles, was elected Councilor to fill the unexpired term of Dr. Harry H. Wilson, Los Angeles, incoming President-Elect. Dr. George H. Kress, San Francisco, was elected Secretary-Treasurer-Editor.

(both, by the way, members of the Stanford-Cooper Medical College class of 1895), that neither of these colleagues has failed to meet each and every call made upon him. More than that, to Doctor Roblee, through a tour to component county medical societies in the northern sections of California, and to Doctor Dukes, for a series of visits to county units in the southern section of the State, much credit must be given in laying the foundation for a more unanimous reaction to the medical service plans on periodic payment basis, as promulgated by the California Medical Association, that have found concrete expression in the separate organization, now known from one end of the State to the other as "California Physicians' Service."

So, also, in many other activities concerning which they have been consulted, Doctors Roblee and Dukes have at all times been ready to give willing and efficient service.

In bidding adieu, then, to Doctor Roblee, as he lays aside the extra responsibilities of the presidential office, the Association at the same time extends its welcome to incoming President Charles A. Dukes as he assumes the obligations of his new field of work. His past record, in many lines of altruistic service in medical practice and organization, is of so creditable a nature that all members of the California Medical Association may feel sure that the interests of the profession will be most punctiliously safeguarded.

* * *

California Medical Association Welcomes All Newly-Elected Officers.—And now, some words of welcome to the new president-elect, whose name, at the time of this writing, we of course do not know. Whosoever may be selected by the House of Delegates at Del Monte on May 3, 1939, likewise has the good will of all members of the Association. The problems immediately before us, while the Legislature is in session, will probably continue as problems, to be met at the next legislative session. The president-elect, therefore, will need to be actively alert, not only in 1941, but prior thereto, in order that no major political situations of a surprise nature be thrust upon the already overtaxed profession.

That the newly-chosen president-elect and councilors will join with other colleagues in official positions to meet courageously and in an alert manner all issues having to do with medical practice and public health standards we cannot doubt.

To each and all such administrators the Official Journal, on behalf of the members of the California Medical Association, pledges loyal and generous service, and tenders its best wishes for most successful terms of office.

GOVERNMENTAL HEALTH INSURANCE PROPAGANDA

Emotionalism Not Conducive to Clear Thinking.—Strange as it may seem, it is nevertheless a fact that, under the influence of emotional partisanship, persons otherwise looked upon as honest are not infrequently guilty of making misstatements in support of causes they espouse that are far removed from the real truth. An example of this weakness in human nature has been repeatedly manifested in the speeches of certain proponents of compulsory health legislation, as they have recently appeared before the public in California, in promotion of the Assembly and Senate bills (A. B. 2172 and its companion measure, S. B. 1128) now pending for consideration before the State Legislature. These proposed laws, so vociferously urged for adoption by certain specific political and associated interests, if enacted, would inaugurate for one of the largest and wealthiest states of the Union a system of medical care radically different from that which has brought to the United States the lowest morbidity and mortality rates of any comparable land in the civilized world!

The fact that the proposed system has not been tried out in any country where environmental and other conditions are actually similar to those which obtain in California seems unworthy of serious thought or acceptance by most of these sponsors of compulsory health laws, who apparently have concluded that, if certain European nations (classified as in the groups of civilized lands) have compulsory health systems, then the systems in vogue there must necessarily be equally adaptable to America. Such factors as the geographic, economic and social welfare elements, and the homo- or heterogeneity of the population types, as well as the quantity and quality of medical service that has been and is rendered to three-fourths or more of the respective populations, are passed over as of little or no moment!

And yet, if the supposed amount of inadequate medical care does not exist in America—and physicians, who should know, do not believe it to exist as so darkly painted—then there is no reason for revolutionary changes in the method of medical practice, through institution of a governmental health system, in which political supervisors would rule over scientifically trained physicians.

* * *

Theorists Are Not Always Logical Thinkers. As one observes the continued activities of the advocates of compulsory health legislation in our State, this defect in logical thinking on the part of many of the theoretical expounders of compulsory health laws—be they in the groups of political, social welfare, or philosophy teachers matters not—becomes increasingly apparent. And nowhere more so than when, in forums or assemblies, or in other public places of announcement or discussion of their cause (under what might be called a spell of auto-hypnosis), they sally forth in gratulatory enunciation of their points of view. If the issues at stake were not of such vital relationship to the health of the people, and to the system of American government as handed down by the country's founders, as well as to the economic background, and therefore to the social welfare of the citizenry of California, the entire matter could be passed over as just "one of those things."

Vicious Features of A. B. 2172 and S. B. 1128. It may be stated that A. B. 2172 and S. B. 1128 are proposed statutes which, if they became laws,

1. Would *not* bring better medical care to the people of California;

2. Would inflict upon the economic interests of the State, in all their expressions, an overload of taxation, creating bankruptcy for many now self-sustaining firms, with loss of employment, and the sad supplements of lowered welfare standards and poverty, with resulting illness, for thousands upon thousands of wage earners; and

3. Would destroy, yes, one might say, debauch, the system of medical practice that has been and is now in existence, in which, both from within and from without, necessary changes in methods are constantly made, in harmony with changing times and needs.

* * *

Physicians Are Practically a Unit Against Compulsory Health Systems.—With such possible end-results, it is not to be wondered at that, by and large, the great majority of physicians are unalterably opposed to compulsory health legislation, as expressed in A. B. 2172 and S. B. 1128, either as originally presented to the California Legislature on January 25, 1939, or in the almost entirely rewritten A. B. 2172, as amended on April 14, 1939. (The long-awaited amendments were finally submitted three days before the public hearing held on April 19 by the Assembly and Senate committees in the crowded Assembly chambers at Sacramento.)

* * *

Public Hearing on A. B. 2172 at Sacramento: A Practically New Bill.—In the Sacramento public hearing it was stated that the persons backing the proposed legislation had given long and serious thought to the drafting of A. B. 2172 and S. B. 1128, so that, when submitted to the legislators, a minimum of amendments only would be needed. It became evident, however, soon after the initial presentation of the bills on January 25, that the proposed laws (seen practically up to the date of their submittal only by those who had previously committed themselves to a compulsory health system) contained many defects in the drafts.

This fact was emphasized at the Sacramento hearing when, in exchange of statement and opinion by Mr. Chester Rowell, Chairman of the Governor's Committee of Twenty-one,* and Assemblyman Ben Rosenthal (who stated he was the author of the bill), with a representative of the Labor Council of San Francisco, it was brought out by the last speaker that the Labor Council had adopted a resolution favoring only health insurance in principle (not A. B. 2172 as submitted on January 25, and certainly not A. B. 2172 as amended from some nine to about thirty pages on April 14). The amended measure, no one, presumably, other than the proponents who were seeking the endorsement of the Assembly committee had had an opportunity to study prior to the evening of the April 19 hearing.† And yet, the proponents hoped to have the Assembly committee bring out a recommendation that it "do pass." Strange inconsistency.

* * *

Professors Dodd and May.—Yet it was just such a measure, with an estimated annual income from taxation sources of almost seventy million dollars (the figures are those read by Paul A. Dodd of California Medical Economic Survey fame, and given by him in the April 19 hearing), that the sponsors of the legislation insisted should be adopted!

With this insistence goes an implied threat to the members of the medical profession that if they do not accept the legislation as proposed the matter will be taken to the people for vote! Witness in this connection some excerpts from the talk by Professor Samuel C. May, Director of the Bureau of Public Administration, University of California, as given on page 383 of the official publication of the Commonwealth Club, issue of March 28, 1939, at which time he stated:

> . . . A voluntary plan covers the worst risks rather than the best risks. *But the most important factor is that from 30 to 40 per cent of the American public are not receiving adequate medical service,** and they are in the income groups which will not join the voluntary plan. . . .
>
> *The bill which is now before the California Legislature has been carefully thought out by people who have been studying this for many years. If it is not adopted by the Legislature, it will go on the ballot and be voted on by the people of California.* I have no doubt whatsoever that if it goes on the ballot it will pass by an overwhelming vote. . . .
>
> So, gentlemen, as a practical problem, you cannot stop compulsory health insurance. The medical profession, instead of continually fighting it—and I am not certain they have stopped that fight—should come into the compulsory plan and see that it is properly formulated and administered, because they are going to get compulsory health insurance, whether they want it or not. . . .

Columnist Rowell, in his dissertation in the San Francisco *Chronicle* of April 25, gives expression to a point of view similar to that of his co-worker, Professor May, when he states:

> There is going to be a health insurance law submitted to the people—by referendum, if the Legislature passes the bill; by initiative if it does not. The doctors would do well to coöperate in passing the bill by the Legislature, so that the vote may be by referendum and on it, as it may emerge from the crucible of legislative discussion, rather than risk that the initiative might be submitted by groups less considerate of the doctors, employers and taxpayers than the framers of this bill have been. To use the sort of Latin in which doctors often write prescriptions: "verb. sap. sat."

The above quotations should be of special interest to physicians, not only because Professor

---

* For names, and complexion as to interests, see CALIFORNIA AND WESTERN MEDICINE, March, 1939, on page 229.

† The item below, which appeared in the San Francisco *Chronicle*, April 26, gives later news on the course of A. B. 2172 in the Assembly. The vote of the committee is the same as the forecast thereon, prior to the April 19 Assembly hearing. Item follows:

Assembly Unit Backs Health Insurance

Sacramento, April 25 (AP).—The Assembly committee on unemployment tonight sent to the floor with a favorable recommendation the Rosenthal bill proposing a State compulsory health insurance program. The decision was reached at an executive session and the vote was 5 to 2.

Under terms of the bill the program would be financed through joint contributions from employers and employees, with the State also bearing a portion of the expense.

Fred Reaves, San Pedro Democrat, who is chairman of the committee, predicted the bill would be passed by the Assembly.

* Editor's Note.—Italics our own.

May and Editor Rowell have sat with the inner council of the sponsors of the compulsory legislation, but also owing to the patently erroneous statement by these laymen, both on the rostrum and in print, concerning the large proportion of American citizens whom they and others claim are receiving inadequate medical care.

* * *

By Contrast, Read a Sane Statement by an International Authority on Public Health.—By way of contrast to statements made by several of the laymen who were associated with the California Medical Economic Survey, and by others in the proponent group for compulsory health legislation who have recently been making speeches on the subject, and to close these comments, we shall quote from an address, "Signs of the Times in Public Health," by Haven Emerson, M. D., Professor of Public Health Practice of the De Lamar Institute of Public Health of Columbia University, an international and much-beloved authority on public health problems, who has made important surveys at home and abroad,[‡] and who said, in a recent New Jersey address:

> . . . That a high quality of care has been given to the sick poor in the past is generally admitted, and is attested by adequate statistical proof of the reduction in morbidity and mortality to their present low levels among such persons.
>
> That some people who need medical attention do not receive it will always be true, as it is today, but the reasons for this are not largely, if at all, due to the inability of these sick to pay for the cost of necessary treatment, but chiefly result from ignorance, superstition, and misinformation growing out of religious beliefs and faith in the promotion of advertised medicaments. *That anything like one-third of the sick now lack medical care*[†] or even that a larger proportion of the population are hindered from gainful employment by preventable and remediable but uncared for disease, as the peroration of the technical committee [lay committee of "technical experts, appointed by President Roosevelt's 'Interdepartmental Committee' "] would try to persuade us with statistics and emotional publicity, is just so far from the truth that it will be forgotten by the public and by the physicians of this country who know it is not so. . . .
>
> . . . We must expect on the experience of other countries that if government actually operates on any compulsory insurance scheme a considerable amount of the services for the sick for people at low-income levels, the cost of medical care of these people will be largely increased, perhaps doubled by the cost of administration!
>
> We have good reason also to suspect that the quality of care will deteriorate, and that the amount and duration of complaints of illness, and the amount of medicaments used will all markedly increase.
>
> The present cause of lack of well-qualified medical care for those really needing it, and wanting it but not receiving it, is chiefly ignorance of available resources, and it would appear that *such sick persons are included in not more than five per cent and in various samplings less than one-half of one per cent of the total population.*[†]
>
> It is as much the duty of the medical profession to warn the public against extravagant and utopian schemes of all inclusive commercial or governmental provision of medical care with their inevitable inferiorities as it is to assure a constantly improved standard of personal service to the sick on the basis of private economic and professional relationship! . . .

Who Are the Proponents and Opponents of Compulsory Health Legislation?—Is it not permissible to state, as regards compulsory health insurance, that there are two camps?

1. *The Proponents* for such legislation, who are largely lay persons, with little inside or expert knowledge of medical practice and service, who expound theoretical plans supposedly based on the experience of peoples in other lands, but which, if logical and clear thinking be observed, are not applicable to California; and

2. *The Opponents,* the leaders of whom are the practitioners of medicine, to whom America is so greatly indebted for having the lowest morbidity and mortality rates of any civilized country[†] (the compulsory health system countries not excluded), and who, probably up to 90 per cent or more, are opposed to a compulsory health system of medical practice, their opposition being reinforced by public health experts of wide experience and international reputation, such as Haven Emerson of New York. Fortunately, also, allied with this group are the large and small business interests of the United States, through whom much of the prosperity that has made for higher standards of living has been developed.

In conclusion, it may be affirmed that if a health system were to come into existence in California such as is contemplated in the proposed law known as A. B. 2172, the people of California, in every walk of life, would rue and doubly rue the day on which they took the advice of false prophets to sell their birthright for a mess of pottage!

AUSTRALIA'S RECENT EXPERIENCE WITH A COMPULSORY HEALTH SYSTEM

Misstatement Regarding Universal Success of Compulsory Health Insurance.—Proponents of a governmental compulsory health system for California have emphasized during the last several months, and almost overstressed their statements, that compulsory health systems have been great successes wherever tried. Some brief excerpts, however, from the speech of Mr. Chester Rowell of San Francisco (Chairman of Governor Olson's Committee of Twenty-one on Health Insurance, of which committee Barbara Nachtrieb Armstrong is secretary, he and she also having held similar positions when the abortive attempt was made some two decades ago to use California as the guinea pig for a compulsory health system), may indicate why the statement above is here given. We quote from page 375 of *The Commonwealth* (Vol. XV, No. 13, for March 28, 1939), where Mr. Rowell states:

> . . . Now, all the way from the Chinese coolie up to the highest and most developed civilized nations in the world, health insurance is in operation. . . .
>
> . . . The rest of the world has abundant experience in applying health insurance to non-occupational diseases—more than fifty years in Germany, a quarter of a century in Britain and other countries. It now covers the civilized world—except for this country. . . .

[‡] See "Who's Who in America," 1938-1939, on page 838, for the record of past services of Professor Haven Emerson.

[†] Editor's Note.—Italics our own.

[†] See in this issue, for example, the record of California for the year 1938, on page 387.

Australia's Repudiation of Its Recent System. Because of declarations such as the above, it may not be out of place to call attention to the recent experience of Australia, where propagandists for a compulsory health system were successful in securing the enactment of laws not greatly dissimilar from those now being so assiduously advocated in California by certain well-recognized interests.

Read, by variation, not the supposed laudatory commendation of the peasant class of Germany or the very low income wage-earning group in England, on the beneficent nature of compulsory health systems (as so frequently portrayed by American proponents of such legislation), but what has actually come to light in a recent real experience with compulsory health insurance among the highly progressive, up-to-date and forward-moving Australians!

The tale* of the events there, as cited below, may be of interest to Editor Rowell and his colaborers, and not without deep significance to Californians, should their citizenry ever be so unfortunate as to embark upon a similar compulsory enterprise:

> National Health Insurance Abandoned †
>
> The commonwealth government of Australia has now decided to abandon completely its scheme for national health and pensions insurance. In a determined effort to preserve the plan even if only in skeleton form, several alternative schemes less comprehensive in nature were considered, but the agreement to abandon the whole insurance act was reached today with only two members dissenting. The treasurer (Mr. R. G. Casey), who evolved the scheme and fathered it through Parliament, has now emerged as one of the strongest advocates against it. Reasons advanced for this decision are fear that the financial burden involved may be so great as to stifle the normal developmental expenditure if it is allowed to fall simultaneously with the heavy defense program to which the ministry is already committed, fear of the repercussions from the cost of insurance while the greater part of the commonwealth is suffering from the effects of severe drought and widespread bush fires, and a recognition of the fact that throughout Australia the act is highly unpopular and that its introduction against the wishes of the people may lead, ultimately, to grave political consequences.
>
> The opposition to the scheme in the ministry itself, although strong when Parliament adjourned in December, has increased immensely since. In the past two months, members of the cabinet have moved freely in their electorates and have in many cases been astonished at the intensity of public feeling against national insurance.
>
> The abandonment of the scheme will cost the commonwealth government at least 750,000 pounds and perhaps 1,000,000 pounds, according to estimates made by the National Insurance Commission. Large sums of money have been spent on the initial steps for its establishment, and numerous "approved societies" have incurred heavy expenditures to cope with the new responsibilities which they were prepared to undertake. Already 156 such societies have been formed in Australia, sixty by trade-unions, fifty-nine by friendly societies, and thirty-seven by miscellaneous organizations; wages contracts have been entered into with staffs, and many men have left lucrative posts to take administrative positions with the government or with approved societies. The government has not yet considered whether the whole organization which it created will be disbanded immediately or whether it will be kept to form a nucleus for the proposed national register (for defense purposes). The British Medical Association in Australia has been opposed from the start to national insurance as proposed by the government. It is to be hoped that this abandonment of the present scheme will furnish an opportunity for drawing up at some future date a scheme more universally acceptable, to be put into practice at a time when the nation is better prepared to handle developmental measures.

Other State Association and Component County Society News.—Additional news concerning the activities and work of the California Medical Association and its component county medical societies is printed in this issue, commencing on page 367.

EDITORIAL COMMENT†

THE PELVIC FLOOR

There is no doubt that the mooted question of what constitutes the most important natural supports has had more different answers, by more different men, than perhaps any other gynecological question. Abundant reason exists for the wide discrepancies in opinion, depending upon the investigator, whether anatomist or gynecologist. For the anatomist there exists the plain evidence of the different normal tissues which make up the pelvic walls, with little or no speculation upon the pathological state. The gynecologist, on the other hand, views first the pathological changes which may occur, whereby the basic support of the pelvic contents are either wanting or greatly insufficient. Having determined the results of these changes, he sets about to effect a restitution of the normal. This is accomplished by operation about the vagina, or entering the abdomen from above.

When we review the anatomy of the pelvic floor, with its related structures, we see why either method of attack may be necessary. We see, also, that what appears at times an incomplete operation, is met with a splendid functional and symptomatic result.

The pelvic floor may be divided into two parts—a superior and an inferior—on account of their anatomical relations. The inferior pelvic floor consists of voluntary muscles, their sheaths or fascia, some areolar tissue, blood vessels, sheaths and nerves. As this is not an anatomical paper, but rather gynecological, the anatomy is but grossly referred to.

The chief muscles of the female perineum are, of course, the levator ani and the cocygeus which, according to anatomies, support and raise the floor of the pelvis. They are chiefly swung between three important points—rami of the pubes, central raphe coccyx, and sacrum behind. These muscles lie between an important fascia which forms their sheath, and which is derived from the obturator and recto-fascia. The obturator fascia covers the inner surface of the obturator internus muscle; it is attached to the iliac portion of the iliopectineal line, to the body of the pubis, and to the great sacrosciatic ligament and notch. Below it joins the falciform process of the great sacrosciatic ligament, and binds the ischiorectal fossa externally. Near its upper margin it gives off the anal fascia, which covers the levator ani and binds the ischiorectal fossa internally. The fascia of the pyriformis is continued back from the obturator muscle. The rectovesical fascia is attached in front to the back of the pubis, and is laterally separated from the obturator fascia. This fascia, covering the upper surface of the levator ani muscle, passes to the upper surface of the vagina to form the front of the sheath of the rectum. In front it is continued to the upper layer of the triangular ligament. Thus, this fascia forms the staunch support of the ligaments of the bladder and rectum.

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* From the *Journal A. M. A.*, April 8, 1939, on page 1402.

† From our regular correspondent: February 14, 1939.

† This department of California and Western Medicine presents editorial comments by contributing members on items of medical progress, science and practice, and on topics from recent medical books or journals. An invitation is extended to all members of the California Medical Association to submit brief editorial discussions suitable for publication in this department. No presentation should be over five hundred words in length.

When one compares these relatively poorly developed muscles with those of the rest of the body, which must bear constant stress of tension and work, it becomes evident from the ever present pressure from above that the muscles, themselves, were scarcely intended, even in a slight way, to represent support. They have always appeared to serve some local function of the vagina and rectum, though in no sense as an important muscular support. The interposition of the vagina nullifies any intention of these muscles as supports. This slit offers abundant room for the uterus, as a wedge, whenever that organ, with bladder and rectum, begins to prolapse.

In spite of the above, almost every authority stresses upon uniting the torn edges of the levator muscles in repairing the perineal floor. Yet, when this is done, only a few torn strands of muscle are found, surrounded by well-developed fascia.

It is evident that the inadequate strands of muscle fibers cannot act as supports, while the strong fascia in this region can; hence, the importance should be placed where it belongs, namely, upon the fascia. The muscle itself affords movement, resiliency, and adaptability. For example, could we assume that the well-developed recti, back muscles, neck and thigh muscles, act as efficient supports without their strong sheaths. Notwithstanding these facts, almost every authority and textbook abound with the importance and significance of this poor, frazzled and torn levator muscle, and no emphasis is laid upon the torn fascia. The important thing is, as we have come to learn from our own cases, that the perineal fascia is the structure of paramount importance, and the approximation of its torn edges is the operation of necessity.

Now, in view of the above facts, we know that uteri prolapsus is due to weakness in the pelvic floor, and insufficiency of intrapelvic and uterine supports. A tight, well-closed vaginal outlet is the most important factor in retaining the uterus within the pelvis.

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SKIN TEST FOR ALCOHOL TOLERANCE

That individual susceptibility to ingested alcohol can be titrated by the endermic injection of ethyl alcohol was recently claimed by Dr. John M. Nagle[1] of the Psychiatric Clinic, Agnews State Hospital, California, in a paper, presented by invitation, before the San Francisco meeting of the Association for the Study of Allergy. If the reliability of the Nagle skin test is confirmed by other investigators, the test would be a valuable addition to the practical clinical technique, and might lead to new and more effective methods of therapy and control of alcoholism.

That there are wide differences in the susceptibility of different individuals to ethyl alcohol is now generally recognized. Recent studies by the Psychotechnic Institute,[2] Dresden, Germany, for example, show that 20 per cent of all normal individuals are rendered psychologically incapable of safe automobile driving as soon as the alcohol content of the blood stream is increased to 0.02 per cent. This is an amount equivalent to the alcohol content of one small bottle of beer, assuming that the beverage is completely absorbed from the gastro-intestinal tract. At the other end of their susceptibility scale, the Dresden investigators claim that 10 per cent of all individuals remain perfectly sober, even after the alcohol content of the blood stream is increased to six times this amount.

If the complex psychological tests used by the Dresden investigators can be replaced by a simple skin test, as Doctor Nagle affirms, a feasible scientific diagnosis of alcoholic intoxication will be made possible. Methods now official in certain European countries are unscientific. In Sweden, for example, a man is legally intoxicated as soon as the alcohol content of the blood stream reaches 0.05 per cent, irrespective of the individual coefficient of tolerance. Accepting the percentages reported by the Dresden psychologists, less than half of the individuals are demonstrably intoxicated at this concentration.

In Doctor Nagle's endermic titration, 0.03 cubic centimeters, 60 per cent ethyl alcohol is injected intracutaneously in the deltoid region of the left arm, with a control injection of the same volume of physiological salt solution in the right arm. Almost immediately wheal formation is noted. Since this wheal is fairly constant in size and intensity in all individuals, it is of no diagnostic significance. Surrounding this wheal, however, an inflammatory reaction of varying size and intensity soon develops, reaching its maximum in about thirty minutes. In alcohol allergics this peripheral erythema may be three or more inches in diameter, in extreme cases even extending over the entire surface of the upper arm. About 20 per cent of the two hundred cases tested by Doctor Nagle gave reaction of this severity, agreeing quite closely with the 20 per cent alcohol allergics reported by the Dresden investigators. At the other end of Doctor Nagle's scale, approximately 10 per cent of his tested individuals gave no peripheral inflammatory reaction whatsoever, agreeing quite closely with the 10 per cent alcohol-tolerant group of the Dresden psychologists.

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[1] Nagle, John M., paper read before the Association for the Study of Allergy, San Francisco, June 11, 1938 (to be published).

[2] Foreign Letters (Berlin), J. A. M. A., 110: 1617 (May 7), 1938.

Doctor Nagle supported his conclusion that the proposed skin test is a reliable measure of individual tolerance or susceptibility to ingested alcohol by the histories of one hundred committed alcoholics tested during the past eighteen months in Agnews State Hospital. Habitual alcohol consumption by these individuals before court commitment was, in all cases, inversely proportional to skin tolerance. In many alcohol allergics habitual consumption was less than that of the average nonalcoholic social drinker. In one extreme case, for example, alcohol was not suspected as an etiological factor in the commitment "psychosis," till his skin test revealed a four plus hypersusceptibility. In this case the commitment diagnosis was changed to "alcoholic allergy without psychosis." A very interesting confirmation of Doctor Nagle's conclusion was obtained by susceptibility tests on eleven nonalcoholic volunteers. The minimum number of highballs taken on an empty stomach necessary to cause detectable intoxication (speech defects) was determined for each of these individuals. From data thus obtained, Doctor Nagle predicted the severity of the subsequent skin reaction correctly in ten cases.

In the discussion of Doctor Nagle's paper before the Allergic Association, it was pointed out that ten years ago his conclusion would have been accepted without question. At that time the skin reaction was quite generally considered to be both qualitatively and quantitatively diagnostic of the allergic sensitivity of all other tissues and organs of the human body. During the last decade, however, it has been definitely shown that marked cutaneous sensitivity may be, and often is, associated with a nonreacting bronchial musculature, and that high pulmonary sensitivity is occasionally associated with nonallergic skin. At the present time, therefore, most allergists will be skeptical of Doctor Nagle's claims till the reliability of his test is confirmed by more adequate and detailed experimental or clinical evidence. If confirmed, however, Doctor Nagle has made an epoch-making contribution to medico-legal and clinical technique.

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CONTRAINDICATIONS OF MANIPULATION IN ORTHOPEDICS

Manipulation should be used judiciously, for its use in many cases may be definitely harmful. Particularly is this so when there has been a failure of diagnosis of the condition to be treated, or where the diagnosis has been incorrect. The condition called lumbago, for example (which implies simply the existence of back pain), consists, in fact, of a failure of diagnosis. Probably 90 per cent of the cases of so-called sciatica constitute incorrect diagnoses, the reason being that any pain radiating down the back of the leg is frequently labeled sciatica.

The reasons for this should be clear, but to elucidate: A patient with a diagnosis of lumbago is sent in for treatment. All this means is that the patient has a pain in his back, and that, too frequently, is all the doctor knows about it. Obviously, a pain in the back, or lumbago, may be due to any number of pathologic conditions, such as acute and chronic infectious spondylitis, syphilis, osteochondritis, tuberculosis, spondylolisthesis, or forward slipping of one vertebra on another, the only symptom of which may be back pain. It is probably superfluous to mention fractures of the spine as a contraindication to manipulation, yet certain fractures of transverse processes are frequently missed and, therefore, may be called lumbago.

Many other conditions may be mentioned, but attention will be called only to acute and chronic osteomyelitis, bone tumors, whether primary or metastatic, and finally low-back strain, by which is meant lumbosacral or sacro-iliac strain. This last-mentioned condition is probably that most frequently called lumbago. The reason why manipulation is contraindicated in this condition should be clear when one visualizes what, in fact, is meant by strain. In sacro-iliac strain, for example, the underlying pathology is a rupture or tearing of the sacro-iliac ligaments, or those ligaments which bridge the joint between the ileum and the sacrum, and which constitute its principal support. Coincidental with such rupture or tearing, there is bleeding or hemorrhage from the ends of the torn ligaments and, eventually, organization of the blood-clot and repair by means of infiltration of new connective tissue.

Now, if at any phase of this process a back so affected is manipulated, the reparative process is interrupted, thereby prolonging recovery and adding to the patient's pain. The contraindication to manipulation in the other conditions mentioned is more easily apparent; as, for instance, the dissemination of malignant cells in bone-tumor cases, facilitating metastases, or the production of pathologic fractures, by weakening a spine already structurally weak from disease. In spondylolisthesis, manipulation may increase the deformity, may cause, as in fractures of the spine, pressure on nerve roots or on the cord, as the case may be, resulting in paralyses of varying extents.

As mentioned before, sciatica is frequently an incorrect diagnosis. Sciatica is a synonym for sciatic neuritis, or inflammation of the sciatic nerve. When present, there is, in fact, pain down the back of the leg, but, in addition, there are sensory disturbances and loss of reflexes. The signs are scattered, or they may be referable to involvement of the entire nerve. Incidentally, the condition is relatively rare. On the other hand, pain down the back of the leg is relatively common, and is frequently due to pressure on the nerve roots of one of the nerves which forms the sciatic, by changes in the vertebral articulations at the point of emergence of the nerve. In either instance, manipulation is contraindicated, but particularly so in true sciatic neuritis, where rest, heat, and removal of focal infection should be carried out. It is, of course, almost as absurd to manipulate a leg because of pain down the back of it, when the pain is due to pressure on one of the nerve roots above. It is not only futile as a therapeutic procedure, but it also helps to mask the true cause of the pain and delays investigation leading to proper diagnosis and appropriate treatment. For these reasons, the procedure known as "stretching the sciatic," in the author's opinion, should be completely dropped as a therapeutic modality. In addition to an almost universal contraindication, it is extremely doubtful if the sciatic nerve is stretched by the procedure, and if it is stretched, whether it makes any difference.

Manipulation is also contraindicated in many definitely diagnosed conditions, such as fractures which are not completely healed, acute subacromial bursitis, cases of which undoubtedly have been labeled neuritis of the shoulder, acute and chronic arthritis, and others. In instances of fibrous ankylosis of joints, whether the result of a cured arthritis, or of prolonged immobilization during the healing of a fracture, this modality may be used, but only with extreme caution, lest a fracture result. Hence, it seems wise to use the modality of manipulation only occasionally, rather than almost constantly, as is done by the chiropractors and osteopaths.

In conclusion, the most outstanding contraindication for manipulation is failure of diagnosis, or incorrect diagnosis. When the condition under treatment is known to be a fibrous ankylosis, and almost only then, manipulation may be used with safety and with benefit.

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Explains Means of Preventing the Reactions From Vein Feedings.—Means of preventing the fever and chills which may follow intravenous or vein feedings are explained by Charles M. Nelson, M.D., Richmond, Virginia, in *The Journal of the American Medical Association* for April 8.

Although these reactions have been commonly attributed to various causes, Doctor Nelson says that experiments show the real factor is bacterial contamination of the distilled water used in the solutions for these feedings.

Boiling the water to be used for six hours will destroy the fever-producing agent. Autoclaving (sterilization under steam pressure) for three or four hours will also destroy it. The usual sterilization period tends to enhance its growth.

Even when sterilized by the usual method, the tubing and flasks used in giving intravenous feedings may sometimes cause fevers, as the fever-producing factor may have lodged in them previously while a solution (not autoclaved) was passing through the apparatus.

Doctor Nelson points out that "any organism that is capable of elaborating a fever-producing substance, which thrives at room temperature and which is a common contaminant, may be the offender. No organism will ever be the offender if the distilled water is taken directly from the still—most storage tanks are contaminated by backflow of air when the still cools—and autoclaved immediately."

People who are always taking care of their health are like misers, who are hoarding up a treasure which they have never spirit enough to enjoy.—Sterne.

ORIGINAL ARTICLES

MEDICAL TRENDS*

ADDRESS OF THE PRESIDENT

By William W. Roblee, M.D.
Riverside

Another year in the history of the California Medical Association has come and gone. The by-laws provide that, at the annual meeting, the President shall deliver an address which shall summarize for its members the events of the past year and the problems unsolved or in prospect. Your President presents his report in fulfillment of that mandate.

This has been a very busy and eventful year in organized medicine. Administrative, political, economic, and scientific problems have engaged the attention of your officers, committeemen, the House of Delegates and membership to a larger degree than heretofore.

INCREASING COMPLEXITY OF MEDICAL PROBLEMS

Each year the problems become more complex. The reasons therefor extend far out into the fabric of civilization. Medicine is but one part of this social picture; and much as some of us may wish for a continuation of the *status quo,* such a policy is impossible. The science and art of medicine are not static, its social and economic features are also subject to evolutionary change. Our thought and action must conform to them or we shall go the way of the dinosaur, and the saber-tooth tiger. They were physically powerful, but lack of adaptability to changed conditions eliminated them.

HISTORICAL BACKGROUND

A brief historical résumé of some of the elements of American life that have brought about present-day conditions and problems may profit us.

The American continent was settled by a sturdy, independent group of citizens. They were adventurous spirits who desired freedom from oppression and an opportunity to develop along independent lines. There was room for all on a continent rich in natural resources. Pioneer conditions were not easy and the fit who survived became, because of inheritance and the struggle for existence, a hardy race of independent thinkers, in which the family was the social unit and the family cared for its own. In comparison with our cities theirs were very small towns, life was largely rural, social contacts were confined to small villages and neighborhood gatherings. Life was simple, needs were few and largely provided by the products of the farm.

AUTHOR'S RECOLLECTIONS

My memory goes back to grandfather's pioneer farm in northern Wisconsin and of seeing him cut wheat with a scythe, thresh it with a flail and take it to a grist mill where the miller ground it for a share of the flour. I have seen grandmother at the spinning wheel, spinning yarn from wool raised on their own sheep, then knitting it into various protective garments. The doctor made his calls in a well-weathered phaeton or on horseback, and he not infrequently had to face a blizzard on foot. His financial receipts were small and often in kind; but he was rich in the confidence and affection of the people he served.

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* Address of the President. Given at the first general meeting of the sixty-eighth annual session of the California Medical Association, May 1-4, 1939, Del Monte.

TWO SCHOOLS OF ECONOMIC THOUGHT

Immediately preceding and following the Revolutionary War two great schools of economic thought developed in this country. One, headed by Alexander Hamilton, advocated as rapid a development of industry as possible and a restricted electorate veering toward a monarchy. The other, with Thomas Jefferson as its spokesman, advocated a nation of small rural land holders, a more liberal electoral franchise, and a trust in the common people. There were many other lines of cleavage between the economic thought of these men which lack of time does not permit us to consider in detail.

Out of the very strenuous debates of that period, which were serious enough to result in the death of Hamilton at the hands of Aaron Burr, there developed the American concept of government which, while providing for unity of national life, conserves the highest degree of freedom for the individual.

SUBSEQUENT DEVELOPMENTS

In the meantime the country was being settled by immigrants from northern Europe who rapidly became splendid American citizens. Take the Irish, for example; what would the country have done for policemen, railroad section bosses or politicians if the Irish had remained in Ireland? Its Friendly Sons of St. Patrick, organized before the Revolutionary War and of which George Washington was happy to become an honorary member, has until this day supplied patriotic leadership in every time of crisis affecting our nation. The English, Dutch, French, and Scandinavians were equally splendid additions to our citizenship. Every man and woman worked, dependency was negligible, and when it did occur the family cared for its own. These conditions obtained until after the Civil War. In the 80's and 90's the picture underwent a decided change. By the beginning of the present century good Government land was about exhausted and the population became less mobile. Yankee inventiveness resulted in the development of a "machine age," whereby hand labor became less in demand and population was concentrated in industrial areas. The capitalist owner of the machines found that he could increase his profits greatly by securing a supply of cheap labor which was imported in great quantities, largely from southern European countries.

Big business was ruthless in competition, and its brutal exploitation of the workers became of great economic and social concern. The great organizations of capital were gradually counterbalanced by the slow, but steady organization of the workers into trade-unions with resultant improvement in labor conditions, often arrived at after serious strife and occasional bloodshed.

The center of political and economic life shifted to the great cities and factory centers and the farmer ceased being the controlling force in the nation. During these same years great discoveries were made in the realm of theoretical and applied science, and their application to our lives wrought profound changes in them. I have but to mention the changes in transportation and communication within the life of most of those here today to illustrate the point. Material standards of living were elevated and American citizens became the best fed, housed and clothed, educated and amused, that the world has ever known. The trite remark, that the "luxuries of our forefathers have become our necessities," certainly holds good.

RÔLES OF PREVENTIVE AND CURATIVE MEDICINE

Medicine, both preventive and curative, partook of this great renaissance. The great plagues of the past no longer mow down our citizens; infant and maternal mortality have been greatly lowered; specific remedies, such as quinin, salvarsan, sulfanilamide, insulin, and the curative and prophylactic sera, have been discovered. The advances in surgery have been unparalleled, and the psychiatrists take our minds apart, polish up the wheels and return many victims of mental disease to useful citizenship.

Of the three great agencies that limited population—famine, pestilence, and war—two are largely under control, and only war is functioning in the same old efficient manner.

Hospital care for sick people has been established with resultant saving of many lives. Few of the younger men in the profession realize that many of their older colleagues, who are their competitors, went through the horse-and-buggy, kitchen-table stage of medicine and surgery.

The factors enumerated have doubled the life expectancy in the past fifty years and the population of the world in the last one hundred years—a greater increase than in the preceding two thousand years.

We were geared in territory, in population, in business and in ideas to a continuously expanding world. There were wars which consolidated the existing system, but none of which disrupted it. The normal state was peace. Democracy had arrived in the advanced countries and appeared on the way elsewhere. Everything had grown so fast during our lives and that of our fathers that we forgot how small the earth was and imagined our particular sort of progress would go on forever. No one doubted that the able and energetic man could get ahead, nor questioned the desirability of his free opportunity to do so. We thought that we had arrived at the goal of human progress and that nothing remained but to improve, on the same lines, the job already done. It was a generation satisfied with itself and the world.

HOW AND WHEN THE CENTURY CLOSED

The century closed, not on its chronological date, December 31, 1900, but fourteen years later when the world with which we had been so satisfied cracked to pieces, never to be restored. Since then, to be sure, there has been progress even of the old sort, and it is not over. But we have discovered that the earth is a limited planet on which there will never be room to do again the spectacular expansions which the nineteenth century saw. However, out of this time of confusion must come something constructive. It will not be the restoration of the nineteenth century, much as some of us would like it. But neither will there be discarded the truths, a repudiation of the standards, the rejection of the experience which it and its predecessors bequeathed. Medicine has, and must continue to share in the adjustments which social evolution has forced upon the modern world.

Many factors enter into the picture of present-day civilization as it exists in this country, but those enumerated will suffice to illustrate the points that I desire to discuss with you today.

PRESENT-DAY PROBLEMS

First: Famine and pestilence having been abolished, mothers and babies conserved, generally better housing and food made available, preventive and curative medicine and surgery advanced, what has been the result? It is perfectly obvious that there has been a greatly increased number of people who live to old age.

Second: Industry has no place for the elderly citizen. A man beyond forty or forty-five has a hard time securing a job or holding it after he gets it.

Third: Because of war, dictatorial restriction, tariff walls and competition developing in other countries and dire want therein, commerce has been greatly dislocated. The prunes of Santa Clara, the peaches of San Joaquin, the oranges of the South, no longer find a ready market in other countries. Economic conditions confronting our great agricultural population have been very trying for the past several years. Many of our usually solvent independent farmers have had great difficulty in securing sufficient return from their crops to remain solvent. The dread of the unusual expense entailed by catastrophic illness hangs heavily over them. Your Council and special committees have had several conferences with the State Farm Bureau leaders. They are a splendid group of citizens, and we were able to acquire a knowledge of our mutual problems that will be invaluable.

They desire an insurance program and a moderate liberalization of admissions to the county hospitals. They frankly say that unless we present a helpful program they will consider a connection with a private insurance group and join with those who advocate county hospital admission on as free a basis as are the public schools for the education of their children.

These factors and many others, some of the most serious of which are domestic and political, combine to cause serious unemployment. About 10 per cent of our citizens are without jobs and their dependents suffer with them.

The machine age is upon us, hand labor will be continuously less in demand. It is perfectly obvious that social and economic life must be readjusted to these changed conditions. The basic needs of mankind, viz., food, shelter, clothing, and care for the sick and disabled—must be supplied. A study of any of these factors must take them all into consideration. Many such studies have been financed and made by philanthropic foundations, the Federal Government, and special interests.

APPLICATION TO CALIFORNIA

But we must narrow our consideration to our own State and the problems of sickness herein. We note the studies made by the "Committee on the Costs of Medical Care," under the chairmanship of Dr. Ray Lyman Wilbur, in 1929 and 1930; the study made by Margaret Klem in 1935 for the State Relief Administration; our own economic survey in 1935-1936; the survey now being completed by the SRA, and various special studies made by the Farm Bureau, organized labor, etc.

It is to be noted that none of these studies were made by doctors of medicine, but all were made by lay social workers. Our own survey was supervised by a university economist, the field work being done by untrained State relief workers, a mistake that we have had cause to regret. None but experienced doctors of medicine can accurately evaluate a sickness or disability problem. This has been abundantly proved by our own experience. The basic conclusion reached by the lay surveys is that at least one-third of our population is without adequate medical care. You and I know that such a condition does not exist in this State. I have visited every county society in California and I have put the question to our members individually and collectively, and the reply has been invariably that any person applying to a doctor of medicine for medical care either will receive it at once or be directed to where it can be secured.

The State Medical Society of New Jersey has made a survey by its own members, and they have reached the conclusion that not over 5 per cent of their people are not receiving adequate care and that the lack is largely of their own choosing, the facilities being available if called for. Organized medicine is fully conscious of the medical needs of the public, and is willing and able to meet these needs, and has been doing so at the rate of one million dollars of free service per day during these years of special stress!

CONCLUSIONS OF THE LAY ECONOMISTS

The major conclusions reached by the lay economists and socialists are three in number:

First: That one-third of the people are without adequate medical care.

Second: That some form of sickness insurance under governmental regulation is the answer.

Third: That this must be compulsory.

These conclusions have been publicized from the platform, the press, the "halls of learning," and legislatures, until a large portion of the population believes them to be true. Any statement can be iterated and reiterated often and vociferously enough to cause its acceptance by many people, and in fact very many of our people are thinking and saying that they know better than the doctors how medicine should be practiced. They do not question the doctors' ability to treat the sick, but they do question the *modus operandi* by which his skill shall be available.

ANALYSIS OF THE CONTENTIONS

Of the three basic contentions just enumerated the medical profession is in hearty accord with the initial clause of the second, namely, that an application of the insurance principle to the hazard of catastrophic illness is a proper measure, and organized medicine has laid down a set of principles to guide any such endeavor. These principles safeguard both the patient and his physician. They provide for the free choice of physician, no interference with medical practice by a political agency or organization for profit, and no compulsion. The aim is to provide adequate medical care for all the people by the physician of their choice at a price that is fair to all the people, including those who render the service.

PROVISION FOR MEDICAL CARE ON A PERIODIC PAYMENT BASIS

The principle that a person in time of physical and financial competence may provide on a budget basis, by fractional payment, for catastrophic need, is sound, and to be encouraged. This common-sense application of basic principles, however, does not satisfy the agitators for radical socialistic treatment of the problem. A goodly number of persons high in the councils of the State, both nationally and in our own State, and even a small minority of our professional colleagues, will not be satisfied with anything that is short of compelling regimentation of both the doctor and his patient. They would provide for another European experiment in social economics which would be dictatorial, un-American, political, regimental, and entirely beyond any guidance or control by the doctors of medicine who are best fitted by experience to handle the problem. This is a far cry from the principles enumerated and fought for by our forefathers, to which I called attention early in this address. They fought compulsion, regimentation and unjust taxation in every way possible. Are we, then, their sons, to flaunt their example and sit supinely by while these things are forced upon us?

The inherent right of both the patient and doctor for protection is largely ignored by the economists, social workers, and politicians in the plans they evolve. Medicine cannot be practiced on a mass-production basis. No compulsory panel system can assure the individual that careful attention to which the American people have been accustomed.

RÔLE OF THE PHYSICIAN

The physician has also been vested by custom and the State with certain rights that cannot lightly be cast aside. He has, in perfect good faith under the law of the land, spent years of time and at least $15,000 in cash in acquiring the necessary training for his professional work. Medicine is big business. The ten thousand doctors of medicine registered in this State spent not less than $150,000,000 in their preparation for service. They have families depending on them. The State has licensed them to conduct their professional work in competition with their fellows, each man making a success or failure in accordance with his capacity and worth. This is the American way, and we insist upon its continuance.

STUDIES BY ORGANIZED MEDICINE

The officers and committeemen to whom you have given authority to care for your interests have not been derelict in their duty. The American Medical Association and our own State Association both felt impelled to call special sessions of their Houses of Delegates for the consideration of pressing economic questions involving our profession. At these sessions the recommendations of your officers and committees were received, policies were debated and conclusions arrived at with which you are familiar.

In this connection I quote as follows from the annual report of the Director of the Bureau of Economics of the American Medical Association:

"Interest in Medical Care Plans.—Since the special session of the House of Delegates in September, 1938, some forty or more medical societies have sought assistance in the study and development of forms of medical service suited to their respective localities.

"The growing interest of medical societies and of the public in special arrangements for organizing payments for medical services can be almost directly measured by the increasing number of experiments conducted by state and county medical societies. In 1934 about 150 plans for distribution of medical services were being conducted by medical societies in various communities in the United States. By 1935 this number had grown to 200, by 1936 to 250, by 1937 to 350, and at present the number is in excess of 450.

"The existence of these organizational plans for the delivery of medical services is a direct refutation of the assertions that have been made concerning the unwillingness of the medical profession to tolerate change in the arrangement for payment for medical services. As a matter of fact, medical societies throughout the United States have in operation more experiments with new plans for the distribution of medical services than all the proponents of group payment plans have ever proposed."

CALIFORNIA PHYSICIANS' SERVICE

We, in California, have responded to the call and are rapidly perfecting a plan whereby prepayment of medical care on a coöperative basis can be secured.

The organization of our Physicians' Service corporation has entailed a tremendous amount of work on the part of the Council, the legal department, the Board of Trustees, of the corporation, and the special committees. We owe them our heartfelt appreciation. Such a state-wide effort has not heretofore been undertaken, and its progress is being observed with keen interest throughout the nation. It is an honest effort to supply, under proper auspices, a service of which the people at large feel the need. This effort will settle the question as to whether the public generally will patronize such a service. We believe it to be in line with modern economic thought.

The question has been asked repeatedly why was such a plan not offered ere this? The answer is that, in the opinion of your committees which have had this study in hand, neither the public nor the profession were ready for it. This year the various interested lines have converged both within and without the profession, and the time seems ripe for such a social experiment. The details, up to this date, will be supplied by the speakers who follow me on this program.

OTHER POLITICAL PROBLEMS

Our political interests have been this year very important, as there has been both a general state election and a session of the Legislature to keep under observation. Under the guidance of our legislative and special committee, the antivivisection initiative was decisively defeated. There is the usual collection of proposed laws in the Legislature which interest us. Some of them are very vicious, and they are demanding the close attention of our Legislative Committee. Any calls for assistance from the membership at large that may be issued must, as in the past, be loyally responded to.

The next regular or special state election will see other initiative measures qualified for the ballot. We hope to have a Basic Science measure for approval of the electorate at that time. These measures, both good and bad, will require our energetic attention.

SCIENTIFIC ACTIVITIES

Our scientific work is being well handled. The County Society programs are uniformally excellent, the state-wide postgraduate sessions are justifying the work of the committee, the program arranged for this annual session is unusually attractive, and we trust that those in attendance will take part freely in the discussions.

MEMBERSHIP

Membership: Our membership for the year 1938 reached an all-time high. We certified 6,219 members in good standing to the American Medical Association for that year. I would urge continued vigilance on the part of the secretaries of county units in order that all eligible, desirable doctors of medicine may be enrolled.

WOMAN'S AUXILIARY

I desire to draw attention to the excellent work done by our Woman's Auxiliary. Their acquaintance, one with another and with their husband's problems, has developed a solid substantial group of helpers that is wielding a very powerful influence for scientific medicine. In behalf of the Council, I extend to them warmest appreciation for their helpful influence.

COUNTY SOCIETY VISITATION

Your President has enjoyed visiting the county societies. California is an unwieldy State to administer, and a systematic visitation of our county units is a time-consuming effort; but it is well worth while. A first-hand discussion of our problems profits both the society members and especially the visiting officials. I recommend a continuance of that work.

THE FUTURE

As for the future of organized medicine I have no fear. We shall have our differences of opinion as to policies and leadership, but they will be solved in the American way. In the future, as has been in the past, after free and frank discussion we shall acquiesce in the will of the majority. Any other course is unthinkable.

Finally, your President desires to express his heartfelt appreciation for the support and friendly consideration that have been extended to him, and he requests that the same loyal support be given to President Charles A. Dukes during his coming year of service.

X-RAY TREATMENT OF CARCINOMA OF THE BREAST*

By Lyell C. Kinney, M.D.
San Diego

Discussion *by William E. Costolow, M.D., Los Angeles; Alson R. Kilgore, M.D., San Francisco; Robert S. Stone, M.D., San Francisco.*

BETWEEN the enthusiastic claims of some radiologists and the iconoclastic statements of some surgeons there are certain proven facts concerning the value of x-ray in carcinoma of the breast that can now be accepted. Any critical estimate must be based on a careful analysis of what constitutes early curable cancer and what must be considered late cancer, where only palliation can be expected. It is certain that x-ray cannot replace surgery in early operable carcinoma of the breast, and it is equally certain that radical surgery cannot replace x-ray or improve the palliation in late advanced cancer. The important problem is how far, if at all, surgery and radiation should overlap in the treatment of carcinoma of the breast. Early carcinoma of the breast where the growth is limited to the gland, or Group 1, is solely a surgical problem. The radical surgical procedure is well standardized, and the five-year cures have reached a constant level of approximately 75 per cent in well-organized clinics. There is no evidence that radiation, either before or after surgery, will improve this result. There are certain cases that are inoperable because of age or physical condition, where it is necessary to resort to radiation instead of surgery, but the best that can be expected is a 45 per cent survival rate, in contrast with a 75 per cent obtained by radical surgery.

PRACTICAL PROBLEMS

The practical problem arises as to which case is early and localized without extension to the axillary glands. There is approximately a 30 per cent error in the clinical estimate of axillary metastasis by palpation; that is, the palpable glands may not be metastatic, and there may be small metastatic glands that are not palpable. Another practical consideration is whether a localized tumor of the breast is, or is not malignant. In the absence of aspiration biopsy, which is not available or accurate in most clinics at this time, the final diagnosis must be made by surgical excision and frozen section.

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* Read before the Radiology Section of the California Medical Association at the sixty-seventh annual session, Pasadena, May 9-12, 1938.

It seems logical at this time to consider any localized, freely moveable lump in the breast as a possible carcinoma that should be immediately excised, with preparations made for microscopic diagnosis and for radical surgery at the time of the excision if proved malignant. If the pathological survey of the axillary contents shows no evidence of metastasis, there will be no indication for radiation. If, on the other hand, metastatic glands are discovered the case is no longer of Group 1, and the question of postoperative radiation must be considered.

There is no evidence at this time to justify extensive preoperative radiation or ovarian sterilization before a microscopic diagnosis is made in an early tumor of the breast without palpable axillary metastasis. The only indication is immediate microscopic diagnosis coincident with radical surgery if the growth is malignant.

LATE CARCINOMA OF THE BREAST: GROUP 3

Late carcinoma of the breast, or Group 3, where the growth is extended beyond the line of defense in the axillary glands, is strictly a radiation problem. According to Bloodgood, where the glands at the apex of the axilla are involved there is less than 5 per cent chance of five-year cure from surgery. If the axillary glands are fixed or massive, if there is involvement of the supraclavicular glands, if the growth is fixed to the chest wall, if there is extensive involvement of the skin or multiple skin metastases, or if roentgenographic survey shows distant metastases, the case is inoperable. There is no method today that will offer any appreciable percentage of five-year cures, and the problem is that of securing the greatest palliation. The attempt at radical surgery in these cases will shorten the patient's life, increase the suffering, and cannot be justified even from a palliation standpoint. Furthermore, the recession of such a growth under radiation does not render the case operable or increase the chance of radical surgery being curative or palliative. On the other hand, fractional radiation carried to skin tolerance will usually arrest the growth and the glands in a large percentage of cases, and will give maximum palliation without prolonged discomfort. There is a small group of cases where growth in the breast does not prove radio-sensitive and where simple mastectomy, following thorough radiation, is indicated to prevent or remove local ulceration. The radiation will not materially increase the length of life in Group 3 cases, but the palliative control from fractional radiation offers so much more than radical surgery that the lines of operability should be strictly drawn to those cases where the growth is localized to the breast or where there is no evidence that it is past the first defense barrier.

OPERABLE CARCINOMA OF THE BREAST: GROUP 2

In about 70 per cent of the cases of carcinoma of the breast that may be considered early and operable, the axillary glands are involved, Group 2. The average case is of at least six months' duration. The well-established results from efficient radical surgery in this group are a 25 per cent five-year cure. Variations from this percentage largely depend on the strictness with which the rule of operability is applied. This 25 per cent recovery rate is the maximum that can be expected from radical surgery, and if this surgical rate is to be increased it must come from the proper combination of radiation and surgery.

There is no proof that x-ray should replace radical surgery where the axillary glands are involved. Adair has shown that with a tissue dose of 3500 r, 22 per cent of these cases will show microscopic disappearance of axillary metastases, but this is not better than can be obtained by surgical removal. In another series of cases treated by radiation alone, Adair has shown that there are no five-year cures when axillary glands are involved. Thus, the surgery must be as radical and complete as possible and as thorough as though no additional help were expected from radiation. There is no reason to believe that where the surgery is incomplete, or where axillary glands are discovered which cannot be removed, postoperative radiation will increase the chance of cure.

POSTOPERATIVE RADIATION

The value of postoperative radiation in increasing the five-year curability of cases with axillary metastases is still seriously questioned. White from the Roosevelt in New York, Graham from the Crile Clinic, Simmons from the Massachusetts General Hospital, and Harrington from the Mayo Clinic, deny that there is any increase in the recovery rate following postoperative radiation. On the other hand, there are large and significant series showing 40 to 50 per cent five-year cures in Group 2, with a combination of surgery and radiation. It is quite significant that the critical analysis from the University of Pennsylvania shows only twelve deaths in known Group 2 cases which had radical surgery and postoperative radiation, and only one death in Group 2 cases which had pre- and postoperative radiation. While statistics differ with various clinics and depend on the accuracy of their analysis as well as upon the efficiency of the surgery and the radiation, and careful attention to operability, there is a wide consensus of opinion that radiation adds 10 to 15 per cent to the life expectancy in Group 2 cases when combined with radical surgery.

MODERN FRACTIONAL RADIATION

The pre- and postoperative treatment of carcinoma of the breast has changed materially with modern fractional radiation. There are two methods at present that can be considered adequate. The first, and most logical, has the approval of Pfahler. The breast is radiated tangentially, including the anterior mediastinum and lateral chest wall. The axilla is cross-fired through at least three areas, including the supraclavicular glands. These five to six portals are treated with fractions of 300 r at 200 K. V. with copper or Thoraeus filter, spacing the dosage on each port at forty-eight to seventy-two hours and reaching a total of approximately 900 r. The cumulative skin dose amounts to about 480 r effective, and the total tissue dose in the axilla averages about 1700 r. This preoperative series is followed within two weeks by radical surgery, and the postoperative radiation is resumed in two to three weeks' time, using the same portals and dosage. Each port is given an additional 900 to 1500 r, making a total of 1800 r for the pre- and postoperative series. The fields after the surgery on the chest wall may be given at 140 K. V., but the cross-fire of the axilla and the supraclavicular glands should remain at or above 200 K. V. This method does not cause undue delay in the surgery, and does not render the surgery more difficult or the healing less prompt or satisfactory.

The second method of radiation that may be considered adequate, attempts the maximum destruction of the carcinoma and the maximum reduction in the axillary glands before the surgery. Using at least two tangential ports to cross-fire the breast, and at least three ports to cross-fire the axilla and supraclavicular glands, fractions of from 200 to 300 r are given on alternate days to each port, building up a total of at least 2000 r per port. Using 200 r every second day or 300 r every third day, this gives a cumulative dose of approximately 800 r on each port and a tissue dose of about 4000 r in the axilla. The skin reaction is marked and the surgery must be delayed from six to eight weeks. The advantages of this method are that 33 per cent of the breasts become microscopically free from carcinoma and that in 22 per cent there will be complete destruction of the axillary glands. However, the two months' delay is a mental hazard to the patient; the operation is more difficult, the bleeding increased and the healing delayed.

RADIATION IN GROUP 2 PATIENTS

When radiation is initiated after radical surgery in Group 2 cases, the problem is considerably different. With the breast and pectoral muscles removed, the chest wall is, on the average, three centimeters thick, and the axillary fold has disappeared. There is little chance to cross-fire the operated area or the supraclavicular glands, and the opportunity to cross-fire the axilla is considerably diminished. Granting that the lethal dose of mammary carcinoma cells lies between 2500 and 3500 r, postoperative radiation must depend upon growth restraint rather than on cell destruction. If the surgery has been complete, and there is residual carcinoma, it must be looked for beneath the operative field in the intercostal lymphatics or the mediastinal chain, or beyond the operative area at the apex of the axilla and the supraclavicular glands, or hidden around the axillary vessels and brachial plexus. In order to cover these areas, the anterior chest wall should be radiated from the sternum to the posterior axillary line and from the costal margin to the clavicle. This may be either by direct portals at 140 kv. or tangential areas at 200 kv. The apex of the axilla and the supraclavicular region may be cross-fired through an anterior and a posterior port; and if the arm can be abducted, by a direct axillary port. The radiation in this region should be at 200 kv. Using fractional doses at 200 to 300 r. and alternating the ports so that the radiation to each is spaced at two to three days, the dosage to each area may be built up to 900 to 1200 r without undue skin reaction. Such a series should be repeated in six to eight weeks, and again at three months after the second series. There is no indication to damage the skin beyond the point of a moderate erythema, which can be repeated at suitable intervals.

The above considerations are applicable only to strictly Groups 1 and 2 cases, where the growth has not passed the first line of defense in the axillary glands. The indications as noted are complete radical surgery, combined with pre- and postoperative radiation, or postoperative radiation when axillary glands are first discovered at surgery, or where the coöperation of the patient or surgeon cannot be obtained for preoperative treatment.

A sharp delineation should be attempted between early operable cases, limited to the breast and low, moveable axillary glands, and between the carcinoma that has extended beyond these points, which must be considered late and inoperable. It is only in the former group that radical surgery is indicated or curative, and where additional radiation may increase the percentage of cure. Failure to appreciate this distinction submits the patient to unnecessary surgery and discredits the value of pre- or postoperative radiation as a curative factor.

The treatment of Group 3 carcinoma is, at best, palliative, and is strictly a radiation problem. At the expense of repetition, carcinoma of the breast should be considered inoperable and suitable only for palliative radiation where there are high, fixed axillary glands, supraclavicular glands, fixation of the breast or multiple skin metastases. Also inflammatory carcinoma should be considered inoperable and belonging to this group.

TREATMENT OF INOPERABLE CARCINOMA

The treatment of inoperable carcinoma should include cross-fire of the breast through as many portals as its size will permit, and cross-fire of the axilla and supraclavicular glands. Fractional doses of 200 to 300 r, spaced at a two-to-three-day interval to each port, are built up to a total dosage of 1500 to 2500 r per port. The actual dosage will depend on the size of the port and the skin reaction required by the clinical judgment of the operator. The underlying principle is that of repeated fractional radiation over a period of three to four weeks, reaching a total of skin tolerance. We, personally, prefer large portals, except in the direct axilla. The breast portals and supraclavicular port are tangential and overlapping, and are carried to at least 1500 r. If the growth does not prove radiosensitive at this dosage or threatens local ulceration, a simple mastectomy is considered after the subsidence of the skin reaction. If the growth is apparently radio-sensitive at this point, the case is handled entirely by radiation.

The treatment of Group 3 cases must be well individualized. In each case the program should depend on a careful survey of the general condition of the patient, the character and extent of the growth, and the extent of possible metastases. A thorough roentgenographic survey of the chest and skeleton for metastases is just as essential here as before surgery in early operable cases. It is at least discouraging to have arrested an extensive growth in the breast and axilla and to find immediately thereafter undiscovered metastases in the chest or cervical spine, or a threatening pathologic fracture in the hip or pelvis. It is this sort of case that tempts the patient's family or the referring physician to feel that x-ray has "scattered the cancer" and to question the value of radiation. If there are distant metastases, these should be recognized and treated, either before or with the attack upon the primary lesion. The presence of metastases will also determine the indication for treatment of the breast, keeping in mind that the ultimate object is maximum palliation.

SUMMARY

1. The prognosis of carcinoma of the breast depends primarily on early recognition and complete radical surgery.

2. Early carcinoma clinically localized to the breast should have immediate biopsy by excision and radical surgery. If metastatic glands are found in the axilla or if the growth is undifferentiated of pathological Groups 3 or 4, the surgery should be followed by postoperative radiation.

3. Early carcinoma, with clinically enlarged axillary glands, should have preoperative radiation before radical surgery, followed by postoperative radiation. If this is not possible, the surgery should be followed by postoperative radiation, as there is evidence that radiation will add 10 to 15 per cent to the expectancy of cure from surgery.

4. The value of x-ray in combination with radical surgery in Group 2 cases does not justify operating cases that are not strictly localized, or expecting the radiation to add to the curability following questionable surgery.

5. Pre- and postoperative radiation are never an excuse for incomplete surgery in operable cases. Postoperative x-ray following incomplete surgery will not increase the probable cure.

6. Carcinoma of the breast, which is not clinically localized to the gland and moveable axillary lymphatics, must be considered late and inoperable. Only palliation is possible, and that is best obtained by radiation.

1831 Fourth Street.

DISCUSSION

William E. Costolow, M.D. (1407 South Hope Street, Los Angeles).—Doctor Kinney has thoroughly covered most of the phases of x-ray treatment of breast cancer. Surgery alone is probably not curing any more cases of cancer of the breast today than it did a quarter of a century ago. Halsted and the men who followed him undoubtedly performed the radical breast amputation as thoroughly as any of our present-day surgeons, and obtained similar results. Operation cannot be made any more radical, nor can one expect a higher percentage of cures from surgery alone. Furthermore, there is no evidence to prove that the cautery or the electroscalpel will produce any better results than the cold steel knife.

It is no wonder then that surgeons now wish to coöperate with the radiologist in trying to better the surgical results in cases with axillary extension, which heretofore have been admittedly poor.

As Doctor Kinney has pointed out, postoperative irradiation has definitely added a small percentage of improvement to the five-year curative results. In addition, there is the enormous palliative value of x-ray in clearing up local recurrences in that group of cases dying of visceral metastasis, before the end of the five-year period.

We agree with Doctor Kinney that the advanced cases with large axillary glands, supraclavicular glands, extensive skin involvement (inflammatory type) or fixation to chest wall, generally should be taken care of by irradiation alone. Some massive involvements will show marked local regression or complete disappearance with thorough x-ray treatment. It may be thought that when these advanced cases are made clinically operable, surgery should be used. Experience, however, shows this to be unwise. These cases are usually of high-grade malignancy, and probably have visceral or bony extension, or some smouldering local areas which may be relighted, with rapid local recurrence taking place. The prognosis in women under forty is extremely poor, regardless of the stage of the disease.

There is a group of cases which offers a field in which five-year curability may be increased. This is stage II, with axillary involvement. This group is now being submitted to preoperative irradiation. This procedure has not been employed long enough for a large group of five-year statistics to be collected. Adair, in 148 operable cases treated by postoperative x-ray following radical operation, had a 40 per cent five-year cure (50 per cent with axillary glands). In 193 operable cases with preoperative x-ray, 64 per cent are living after four years. Adair states that formerly 60 per cent of his operable cases showed axillary involvement, whereas since using preoperative x-ray he had found only 40 per cent with axillary involvement.

Preoperative x-ray should be thorough and operation withheld until the full effect of the treatment is secured and the reaction allowed to disappear. We usually divide the breast and axilla into multiple areas, as described by Doctor Kinney, but apply only 100 r daily to each area, usually to a total of 2000 to 2500 r. The smaller breasts may be covered by two 10 by 15, or 15 by 20 tangential areas, but larger breasts may require multiple areas in order to obtain the desired tumor dosage. Operation is usually delayed until after two months. In our cases there has been very little added operative difficulty, and healing has taken place in all cases.

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Alson R. Kilgore, M.D. (490 Post Street, San Francisco).—It is refreshing to hear this clear and well-balanced exposition of a still controversial subject. I can contribute only complete agreement with Doctor Kinney that the great contributions of radiation to the treatment of mammary cancer have been (1) to encourage restriction of surgery to those cases offering at least reasonable hope of cure; (2) to increase apparently definitely the survival rate following surgery in the more advanced cases operated; and (3) to offer invaluable palliation to inoperable patients.

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Robert S. Stone, M.D. (University of California Hospital, San Francisco).—Doctor Kinney has presented a masterful survey of the subject, with which I am in general agreement. I shall not reiterate those points on which we agree, but shall stress those on which we differ.

Group 1 is a broad grouping which I believe should be subdivided. If the lump in the breast is such that a diagnosis of cancer cannot be made clinically with a fair degree of accuracy, then, of course, surgical excision is in order, with preparation for an immediate radical mastectomy if the frozen section shows it to be cancer. If a presumptive diagnosis of cancer can be made on clinical grounds, then I believe that at least a short course of preoperative radiation should be given. It has frequently been shown that cancer transplanted into an area previously irradiated has a much less chance of growing. Advantage of this should be taken by giving an immediately preoperative short course as a minimum. It delays operation only a few days and does not increase the operative difficulties.

The author showed that there is a 30 per cent error in diagnosis of the axillary glands in supposedly Group 1 cases. It is probably in this 30 per cent of cases that preoperative radiation has its chance to be of benefit. Let us remember that if we can increase the five-year survival by even five in one hundred, it is just as important to save these five women in Group 1 as in Group 2.

In Group 2 patients, I believe that preoperative irradiation should be used for the same reasons as preoperative irradiation in Group 1. In Group 2, because the surgical results are so poor, a thorough course of radiation should be used rather than a short course. It must be remembered that there are practically no statistics on the value of preoperative protracted fractionated courses. To base our opinions of the value of preoperative radiation on older statistics is like basing an opinion of the value of surgery on late nineteenth century surgery.

Another point on which we disagree is on the value of repeated courses of radiation after surgery. If the cancer was found to be limited to the breast and axilla, we should give one really thorough course of irradiation, such that we would not care to repeat, and rest with that. Most authorities are agreed that the chance of irradiation curing lies in the first attack on the disease and not on repeated attacks.

The number of fields to be used and their size will always be a matter of individual opinion. In general, I use a smaller number of fields and larger total doses per port than the author indicates. From sad experience, I should like to emphasize what the author insinuated, namely, that the ports must be arranged so as not to get large doses of radiation in the lungs, either by crossfire or direct radiation.

DERMATOMYOSITIS*

REPORT OF CASE ASSOCIATED WITH RHEUMATIC HEART DISEASE

By Frederick Kellogg, M.D.
Long Beach
and
Felix Cunha, M.D.
San Francisco

Discussion *by Robert W. Langley, M.D., Los Angeles; Hiram E. Miller, M.D., San Francisco.*

DERMATOMYOSITIS is a rare disease best described as an acute, subacute, or chronic disease of unknown origin, characterized by a gradual onset with vague and indefinite prodromata, and followed by edema, dermatitis, and multiple nonsuppurative inflammation of muscle. The first clear-cut cases were described independently by Unverricht,[1] Hepp,[2] and Wagner[3] in 1887.

PATHOLOGY

Early the skin and subcutaneous tissues show edema, infiltration with neutrophils and some areas of hemorrhage. Later there may be desquamation of the surface layers with degeneration of the corium and disappearance of the papillae. The changes in muscle are characteristic. First, there is transudation of fluid and interstitial and perivascular infiltration of leukocytes. The muscle bundles show a patchy involvement, and normal ones may be seen among others showing all stages of degeneration. Later, evidence of regeneration of muscle appears in scattered areas, and there is much increase in connective tissue.

ETIOLOGY

The cause of the disease is obscure. Certain features suggest an infective origin, namely, the first symptoms frequently following some febrile disturbance such as tonsillitis, influenza, measles, rheumatic fever, etc.; the demonstration often of foci of infection; the febrile course; the presence of splenomegaly in many cases; and the relapsing nature of some cases.

Various organisms have been thought specific by different observers, but in many cases no organisms are found. Probably the disease is a syndrome which may result from a variety of causes. All ages are affected, and the incidence in both sexes is approximately equal. The white races have been almost exclusively affected. Winter seems the commonest time of onset.

SYMPTOMS

Following the vague prodromata, symptoms appear insidiously. These consist of increasing muscular weakness with pain, swelling and rigidity, which is usually widespread and symmetrical, and accompanied by a peculiar exanthem and a brawny edema. The muscles alternately feel firm and tough, or soft and boggy. The limbs are most commonly affected and, in contrast to trichinosis, the muscles of the eyes are not often involved. The rash usually has a peculiar heliotrope color and is distributed over the affected muscles. Later in the disease the rash may resemble various types of skin disease, and as an end-result brownish pigmentation is common. Eventually the skin becomes thickened and may even resemble scleroderma.

A high intermittent or remittent fever may be present during the acute stages, but frequently is of mild character. The spleen is often enlarged. Leukocytosis is common but, typically, no eosinophilia is present. Creatinuria has been reported. This is not primary, but is undoubtedly secondary to the anatomical changes in the muscles.

Death is common during the acute stage, usually from intercurrent infection. If the patient lives long enough, the pain and edema begin to subside and fibrosis of the skin and muscles develops, resulting in marked deformity. The skin then becomes hard and inelastic and bound down to the underlying muscles, which may be felt as boardlike wasted bands.

Recovery is often accompanied by residual weakness and contractures, and certain areas of skin may always remain sclerotic. However, it is possible for the patient to recover completely after a most severe attack. Unfortunately, relapses are common. About 50 per cent of the reported cases die, some in the acute stages, but more after months of illness.

DIFFERENTIAL DIAGNOSIS

Dermatomyositis, during its acute stage, may so simulate trichinosis that early reports used the title "Pseudo-trichiniasis." However, in trichinosis, changes are usually most prominent in the

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* Read before the General Medicine Section of the California Medical Association at the sixty-seventh annual session, Pasadena, May 9-12, 1938.

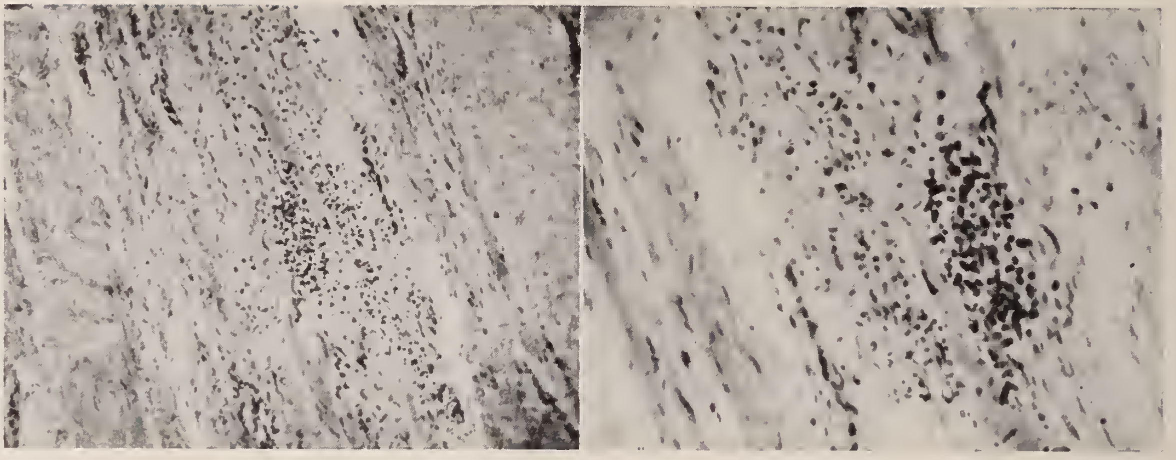

Fig. 1 Fig. 2

Fig. 1.—Photomicrograph of muscle from calf. Note infiltration of leucocytes about muscle bundles and increase in connective issue. (X105)

Fig. 2.—Photomicrograph of muscle from calf. Varying degrees of degeneration of muscle are shown. Note wavy contour of fibers and fibrosis. (X210)

ocular muscles. Eosinophilia, which is uncommon in dermatomyositis, is always present in trichinosis, and larvae may be found in the blood or muscle.

Polyneuritis may cause confusion, especially as in some cases of dermatomyositis the nerves are involved as well. However, in uncomplicated polyneuritis, edema and muscular swelling are absent.

Scleroderma can be excluded in the chronic cases only by the presence of myositis. Many believe that the two diseases are different manifestations of the same morbid process, for sclerodermatous changes often accompany dermatomyositis.

TREATMENT

All forms of therapy have been advocated, none of which have been specific. Stress should be laid upon the prevention of deformity and upon various orthopedic and physical therapeutic measures which should be employed if the patient recovers. The patient presented was treated with autogenous vaccine, as was one other patient reported by McGarrahan.[4] Ordinarily no bacteria are found in biopsy specimens. McGarrahan isolated a culture of Staphylococcus albus from a nasal smear. As this gave a positive intradermal reaction, a vaccine was made and administered with apparent benefit.

REPORT OF CASE

M. B., a 22-year-old female milliner, of Italian descent, was first seen on the Medical Service of the University of California Hospital in September, 1935, complaining of pigmentation and muscular weakness of two years' duration. Eight years previously, at the age of fourteen, she was vaccinated for smallpox. A small brown area of pigmentation appeared at the site of vaccination which extended over the entire upper left arm during the next few years, and similar areas of pigmentation appeared on the right arm. This was accompanied by a decrease in size of the left arm. Two years before entry, at the age of twenty, she noted nodules in the calf of the left leg and weakness of both legs. This was followed by edema and she was treated for congestive cardiac failure, with improvement. However, contractures of her calf muscles developed, so that she was unable to walk flat-footed. For eighteen months before entry she was confined to bed with generalized muscular weakness and stiffness. With the onset of stiffness the pigmentation previously noted spread over the entire body. During the last month of her acute illness she had had fever and profuse perspiration, and had lost thirty-five pounds in weight. No muscular pain had been noted. Infected ingrown nails of both great toes had been present about three years. Her past history was not remarkable, except for "growing pains" at thirteen and fourteen years of age.

Examination in 1935 revealed an emaciated girl with fixation of elbows, knees, and hips in 90 degrees flexion. The ankles were fixed in plantar flexion. Generalized pigmentation was present, with the exception of the nose, palms, and soles of the feet. The pigmentation was mottled and of a dirty-brown color. The pigmented area about the left upper arm had sharply demarcated borders. All extremities were wasted, and all muscles felt indurated and cord-like to palpation. Slight generalized pitting edema was present. The mouth could be only partially opened. The heart was slightly enlarged to the left and right. The rhythm was regular. A presystolic murmur, ending in a booming first sound and followed by a blowing systolic murmur, was heard at the mitral area. The pulmonic second sound was accentuated and reduplicated. The blood pressure was 116 systolic, and 70 diastolic. The abdomen showed an enlarged spleen at the left costal margin. Clubbing of the fingers was present. The left great toe showed an infected ingrown nail. The patellar and abdominal reflexes were barely elicited.

Extensive laboratory procedures, including routine urine and stool examinations, Wassermann test on the blood, phosphorus and calcium determinations of the blood, culture of the blood, gastric analysis and spinal fluid examination, were normal. The blood showed a mild secondary anemia and leukopenia. No eosinophilia was present. Creatinuria was present, the twenty-four-hour output of creatin being 98 milligrams and of creatinin being 218 milligrams. Culture of the toe showed Staphylococcus albus and Bacillus subtilis. A biopsy from the right calf showed characteristic lesions of dermatomyositis (Figures 1 and 2). Culture of tissue obtained at biopsy showed nonhemolytic streptococci.

X-ray films of the chest showed the heart to be enlarged and of a mitral configuration. Films of the lumbosacral spine showed extreme lumbar lordosis. Films of the elbows showed no lesions of bone or joint.

While under observation the patient was febrile, the fever being remittent at times and intermittent at others, reaching maximum of 40 degrees Centigrade. A vaccine was prepared from a mixture of streptococci isolated from a stool culture, and the muscle biopsy and staphylococci from the infected toe. This vaccine was administered intravenously at weekly intervals. With large doses temporary exacerbations occurred, but with small doses improvement appeared. Following the subsidence of the acute involvement, exercises and physical therapy were instituted. At this time the patient was unable to feed herself or to turn in bed. During the past two years improvement has gradually occurred, until now she is able to walk alone with difficulty and can care for herself in bed.

COMMENT

The history and findings of the patient reported are typical of dermatomyositis and show the diagnostic triad of eruption, edema and myositis. Unusual features of this case were the absence of pain, the presence of mitral stenosis, and the isolation of organisms in the biopsy specimen. The onset in this patient was very gradual, and an organism of low virulence, undoubtedly introduced at the time of the vaccination, slowly spread throughout the body over the next few years.

Dermatomyositis may at times involve the myocardium, but never causes valvular lesions as seen in rheumatic heart disease. The mitral stenosis was probably due to rheumatic infection, as manifested by the "growing pains." These preceded the vaccination and were probably independent of the dermatomyositis.

Apparently, an autogenous vaccine was of value in this patient as in that of McGarrahan. Unfortunately, it is seldom that organisms can be isolated from muscle, and it is this fact that has cast doubt on the infectious etiology of the disease. It is of utmost importance, however, that contractures be prevented as much as possible, and that fixation of limbs occur in positions favorable to physiologic function. Following the subsidence of the acute disease, proper massage and graded exercises and manipulation are of inestimable value in rehabilitation.

IN CONCLUSION

1. A case of dermatomyositis is reported which followed vaccination for smallpox and which was associated with rheumatic heart disease.

2. Because of its apparent benefit in this case, further trial of autogenous vaccine in the treatment of dermatomyositis is indicated.

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DISCUSSION

Robert W. Langley, M.D. (1930 Wilshire Boulevard, Los Angeles).—The condition of dermatomyositis occurs infrequently. Its recognition justifies attention and recording. The outlook is usually quite poor. There is little a cardiologist may contribute to this subject. Doctor Kellogg states that dermatomyositis may at times involve the myocardium, but I have been unable to substantiate this statement from any proved cases in the literature. Two fatal cases were recently reported by members of the staff of the Hospital of the Good Samaritan in Los Angeles. Autopsies on both cases failed to show myocardial damage, either gross or microscopic.

There is no question about the diagnosis of rheumatic heart disease of moderately severe degree in this case. The congestive heart failure responded satisfactorily to medical treatment.

Doctor Kellogg suggests, quite rightly I think, that rheumatic infection was associated with, but independent of the dermatomyositis. There may be some relationship between scleroderma and dermatomyositis. Cases have been reported where a transition appears to have taken place. This writer has observed a case of scleroderma associated with rheumatic heart disease. No relationship between the two seemed apparent.

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Hiram E. Miller, M.D. (384 Post Street, San Francisco).—Dermatomyositis is a comparatively rare disease, and it is always of value to report the findings in such unusual cases as this one. The prodromal symptoms in this woman were of very slow onset, extending over a period of eight years or more. She had marked contractures of her leg muscles; pigmentation gradually covered her entire body, but there was no history of an actual dermatitis. She had an associated valvular heart disease, with clubbing of the fingers. Streptococci were obtained by culture from a biopsy taken from the leg muscles. There are probably a number of diverse and only remotely related conditions classified under the symptom-complex of dermatomyositis.

I have observed several patients with this disease. They all have had a dermatitis on the upper face, eyelids and, in most instances, on the extremities. Many of them died due to paralysis of the visceral muscles generally of the respiratory tract. The dermatitis in most instances closely resembled disseminated lupus erythematosis. An associated leukopenia is also observed in this disease. In my experience, a leukopenia is generally found as is recorded in this case, and not a leukocytosis as is stated in the paragraph on symptoms.

I have seen various types of treatment used in this disease, but have not been convinced that any of them have materially changed the course of the disease. Some of the patients recovered and some of them died.

I do not believe that vaccination has played any part in causing the disease in this patient. I think it is unfortunate that this phase of the condition has been given such a prominent place in the conclusions.

INSULIN SHOCK THERAPY IN DEMENTIA PRAECOX: A REPORT OF A SERIES OF CASES*

By Clifford W. Mack, M.D.
and
B. O. Burch, M.D.
Livermore

Discussion *by J. M. Nielsen, M.D., Los Angeles; E.W. Mullen, M.D., Agnew; Samuel D. Ingham, M.D., Los Angeles.*

Introduction.—The treatment of dementia praecox by hypoglycemic shock, according to the method of Sakel, is largely empirical in character. The determination of its value can only be made by clinical application to a large number of cases over a period long enough to see the proportion of successes and failures. As the last four years have furnished much data, it is well for us to review the results and try to ascertain if this dramatic form of therapy merits a place in psychiatric practice.

EUROPEAN REPORTS

The reports from European clinics are much larger than from those in this country. Recent literature indicates that about two thousand patients have been treated all over the world. The greater magnitude of the work abroad may be due to its earlier use there; but this also leads one to believe that it has been given wider application than in America. Sakel[1] first reported 104 cases completed in 1937, in which series there were 70.7 per cent recoveries. If to this figure is added those not having a full remission, but who were classed as fit to work, the total is 86.2 per cent. These were in the group of new cases under six months. The total percentage of recoveries in the series of 104 was 48 per cent, including both old and new cases. This is a startling recovery rate for a disease that has baffled psychiatrists for generations. A more recent article by Strecker,[2] including a report from the Müller Clinic in Switzerland, gives an analysis of 495 cases. The percentage of recoveries of those patients under one year was 57.2; under two years, 27.3; over two years, 11.3. The percentage of improved cases under one year was 22.2; under two years, 34.1; over two years, 32.2. These statistics, showing a recovery rate of 40.4 per cent for the entire series, are decidedly more modest than those just quoted.

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* Read before the Neuropsychiatry Section of the California Medical Association at the sixty-seventh annual session, Pasadena, May 9-12, 1938.

AMERICAN STATISTICS

The American reports are not so extensive, but compare favorably with the European. The largest series comes from the Harlem Valley State Hospital,[3] in July, 1937, and comprises eighty-one cases. There were fifteen cases of a duration under two years, showing recovered and much improved, 66.66 per cent, improved 26.66 per cent; ten cases of two to four years, recovered and much improved, 40 per cent, improved 40 per cent; eight cases of four to six years, recovered and much improved, 37.5 per cent, improved 37.5 per cent; and thirteen cases of six years and over, recovered and much improved, 15.38 per cent, improved 61.51 per cent. It will be noted that there is a recovery rate of 44.4 per cent in the group as a whole if the much improved cases are included with the recoveries. The commonly accepted spontaneous remission rate is from 5 to 20 per cent.

REPORT OF CASES

The following nineteen completed cases are reported, out of a total of twenty-three treated.

Case 1.—B. Age, 16. Some original mental defect. Duration, eleven months. Mental symptoms consisted of violent conduct, hysterical spells simulating fits. Later, in the course of the illness, the patient became apathetic, indifferent, and unproductive. Progressive mental deterioration. *Diagnosis:* Dementia praecox, hebephrenic form. *Treatment:* Total number, 93, with a maximum dose of 140 units. Four convulsions. *Result:* Slight improvement in conduct. Discharged unimproved.

* * *

Case 2.—Bo. Age, 20. Normal youth, except somewhat retiring. Duration, one year. Mental symptoms consisted of delusions of poisoning, periods of extreme mental excitement, great pressure of activity, delusions of mistaken identity and auditory hallucinations. During the course of the illness these periods of excitement alternated with periods of quietude, unproductiveness, and a sad mood. *Diagnosis:* Dementia praecox, hebephrenic, with some features of manic-depressive psychosis. *Treatment:* Total number, 81, with maximum dose of 120 units. One convulsion. There was slight improvement, with diminution of cycles and hallucinations. *Result:* Unimproved.

* * *

Case 3.—Ba. Age, 60. Normal social personality. Duration, four years. Delusions of persecution, despondency, fear of dirt infection and of contaminating other people. Suicidal ideas. Agitated and restless. Pronounced negativism. Physical examination negative. *Diagnosis:* Dementia praecox, paranoid. *Treatment:* Total of 6, with maximum dose of 60 units. The patient died, after receiving 40 units. Cause of death, on clinical data without autopsy, coronary sclerosis.

* * *

Case 4.—T. Age, 40. Always timid, sensitive and overly conscientious. Duration, eighteen years. Symptoms of pronounced mental deterioration, following years of mental disease. Negativistic, unproductive. Mutters to himself and laughs sillily. Listless and apathetic; very untidy. *Diagnosis:* Dementia praecox, hebephrenic. *Treatment:* Total of 96, with maximum dose of 140 units. *Result:* Slight change in conduct, so that patient could engage more in occupations. Unimproved.

* * *

Case 5.—McE. Age, 25. Shut-in type of personality. Duration, one month. Chief symptoms: Violent, impulsive conduct; delusions of persecution that he is to be electrocuted; that he is possessed of the devil. Homicidal threats. No hallucinations. *Diagnosis:* Dementia praecox, paranoid. *Treatment:* Total of 90, with maximum dose of 160 units; two convulsions. *Result:* Recovered. (A report after six months states that this patient is still well and working at his occupation.)

* * *

Case 6.—To. Age, 20. Shut-in type of personality. Duration, nine months. Chief symptoms: Abnormal fear of death; depressed, anxious mood. Excitable and restless. Stereotyped conversation and conduct; mannerisms. *Diagnosis:* Dementia praecox, hebephrenic. *Treatment:* Total of 9. *Result:* Unimproved.

* * *

Case 7.—MacL. Age, 34. College graduate. Normal personality. Duration, four years. Chief symptom: Delusions of persecution. Psychosis progressed slowly. Unable to work for three years because of delusional control and some neurasthenic complaints, with a mild degree of anemia. Outbreak of violent conduct and threats against the authorities caused his arrest and commitment. *Diagnosis:* Dementia praecox, paranoid. *Treatment:* Total of 189, consisting of two courses: the first one of ninety-three treatments, which brought about a remission lasting only two weeks; the second course, ninety-six, with the result that symptoms entirely disappeared. The patient is following normal conduct, but is still in the hospital. *Result:* Improved.

* * *

Case 8.—W. Age, 23. College graduate. Unusually high intelligence—one of Terman's one thousand cases. Duration, two years. Chief symptoms: Inability to continue studies; delusions and suspicions about people; auditory hallucinations. Voices that came from former friends, one of whom kept her constantly hypnotized. Psychosis progressed, with evidence of deterioration. The patient became uncouth in manner and untidy. After some months, delusions changed to feelings of grandeur and ideas of royalty. *Diagnosis:* Dementia praecox, paranoid. *Treatment:* 114 doses, with maximum dose of 110 units. *Result:* Temporary improvement, but final result unimproved.

* * *

Case 9.—F. Age, 25. Normal personality. Duration, one year. Chief symptom: Outbreak of violence because he could not conform to social usages. Arrested and taken to jail. After release he was unable to adjust himself. Psychosis progressed, with delusions of poisoning, and he eventually developed a state of stupor with complete negativism, in which condition he was brought to the hospital. *Diagnosis:* Dementia praecox, catatonic. *Treatment:* Total of 68, with maximum dose of 100 units. *Result:* Recovery. (A report five months later certifies that he is still well and following his former occupation.)

* * *

Case 10.—J. Age, 33. Normal personality. Duration, five years. Chief symptoms: Delusions of poisoning. Violent spells. Homicidal, threatening to kill the family. Unregulated conduct, noisy, screaming, laughing sillily. The psychosis progressed. Auditory hallucinations, interfering with daily conduct. Hallucinations became sexual in content. *Diagnosis:* Dementia praecox, paranoid. *Treatment:* Total number, 68, with maximum dose of 70 units. Three convulsions. The patient improved very much in conduct, hallucinations diminished but did not disappear. No violent spells. The patient was very sociable and able to engage in occupations and exert good self-control among other people. *Result:* Improved, although still in the hospital.

* * *

Case 11.—S. Age, 22. College graduate. Normal personality. Duration, three months. Chief symptoms: Mental confusion. Religious delusions that the world was coming to an end; that certain people were possessed of the devil; that he had power to do miracles. State of great mental and physical excitement continued. Auditory, and possibly visual hallucinations. As the psychosis progressed he became very noisy and disturbing, requiring packs and seclusion. *Diagnosis:* Dementia praecox, hebephrenic. *Treatment:* Total of 38, with maximum dose of 65 units. Two convulsions. Improvement began during second week of treatment. *Result:* Recovered. (Six months after discharge, report indicates that he is very well, and socially adjusted.)

* * *

Case 12.—Wh. Age, 40. Rather retiring personality. Duration, eleven years. Chief symptoms: Delusions of a sexual nature, that she was being assaulted, and persecuted by neighbors and officers. Belief that husband's business was being hampered by her enemies. Delusions about dirt and infection in the house, always washing her hands and cleaning. *Diagnosis:* Dementia praecox, paranoid. *Treatment:* Total of 85, with maximum dose of 60 units. *Result:* The patient improved steadily in conduct and emotional reactions. She became more interested and concerned about her daily life. Delusional content diminished gradually. No new delusions were formed, and she was willing to refrain from any reaction to delusional ideas. Discharged improved. (Follow-up report is satisfactory.)

* * *

Case 13.—L. Age, 15. Rather above the average in intelligence. Duration, three years. Chief symptoms: Loss of application in school. Disturbing dreams. Mental confusion. Auditory hallucinations. Religious delusions. Psychosis progressed, and while in the hospital she expressed many fantastic ideas, such as that she was pregnant, that voices accused her of wrongdoing. Negativistic. Tube-fed. *Diagnosis:* Dementia praecox, hebephrenic. *Treatment:* Total of 96, with a maximum dose of 80 units. Nine convulsions. *Result:* Unimproved.

* * *

Case 14.—Tr. Age, 34. Rather quiet, retiring personality. Overly conscientious. Duration, five months. Chief symptoms: Painful depression. Fear that he had made an error and would lose his job. One month before admission he became very delusional and was placed under complete rest treatment at home. Thought that the company had spies about the house who were going to put him in jail. The psychosis progressed. He would not talk, sleep or eat. There was a severe excited spell, during which he ran about the house in terror, wanted to call the police, and jump out of the window. *Diagnosis:* Manic-depressive psychosis, depressed. *Treatment:* Total of 68 injections, with maximum dose of 140 units. Improvement began one month after treatment started. Symptoms gradually disappeared and the patient became more cheerful and coöperative. *Result:* Recovered. (Three months later the patient was reported well and has since been working at his former occupation.)

* * *

Case 15.—K. Age, 25. College graduate. Very sensitive and seclusive type of personality. Duration, two months. Chief symptoms: Despondency, fear. Delusions that he had caused trouble in the plant and would be discharged. Afraid he would be shot, and attempted to disguise himself. Talked of suicide. Delusion that his reputation had been ruined by certain stories circulated about him in regard to sexual affairs. Believed his presence would injure everyone in his surroundings. *Diagnosis:* Manic-depressive, depressed. *Treatment:* 86 injections, with maximum dose of 200 units. Three convulsions. Improvement began after three weeks. He became more responsive in conversation, and applied himself to tasks and recreation. Psychomotor retardation, depression and delusions remained in evidence, but these gradually diminished and were the last to disappear after return of normal mood. *Result:* Recovered.

* * *

Case 16.—R. Age, 27. Normal personality. Mild depression seven years previously. Duration, one and one-half months. Chief symptoms: Depression. Lack of interest in surroundings. Psychomotor retardation. Hypochondriacal delusions. Psychosis progressed. He became greatly disturbed emotionally and could not coöperate. *Diagnosis:* Manic-depressive, depressed. *Treatment:* Total of 45 injections, with maximum dose of 160 units. He improved gradually each week. At the end of the seventh week he was very much better, and appeared to his wife and others to be entirely well, except for a feeling of inadequacy and worry. *Result:* Recovered. (Three months later patient was normal and able to carry on his business affairs.)

* * *

Case 17.—Ri. Age, 31. College graduate. Inclined to neurasthenic complaints. Duration, nine months. There had been a mental condition two years before, during which he was depressed. Chief symptoms: Confused, restless, and negativistic. Letters showed verbigeration. After a few weeks he became mute. A few spells of extreme excitement and violence. No change during a period of five months before treatment was instituted, except increasing stupor. *Diagnosis:* Dementia praecox, catatonic. *Treatment:* Total of 94, with maximum dose of 120 units. One week after treatment began the patient became less negativistic. In the second week voluntary activity predominated, and after six weeks he engaged normally in occupational and recreational pastimes. Improvement was gradual, with blocking in conversation the last symptom to disappear, but at the end of twelve weeks he was definitely convalescent. *Result:* Recovered.

* * *

Case 18.—Wi. Age, 17. Slow in school. Industrious, but not sociable. Duration, seven months. Chief symptoms: Ill-tempered in school and could not study. He developed delusions that people were making fun of him. Later he was indolent and impulsive, and laughed sillily. Active hallucinations appeared, also delusions of poisoning. Committed to a state hospital. *Diagnosis:* Dementia praecox. *Treatment:* Total of 84, with maximum dose of 130 units. During a period of six weeks there was little change in the patient's behavior, but then he became more interested in activities. The acute symptoms left him, and he showed steady improvement. *Result:* Recovered.

* * *

Case 19. Le. Age, 19. Normal personality. Duration, twenty months. Chief symptoms: State of depression and fear; later, pronounced mental confusion and violent conduct. Untidy habits, destructiveness, inability to feed herself or care for her person. Mental condition grew worse up to time of treatment. *Diagnosis:* Dementia praecox, catatonic type, allied to manic-depressive psychosis. *Treatment:* Total of 72, with maximum dose of 150 units. Two convulsions. Improvement was first noted at the end of the second week, with change in the patient's conduct. She became quieter and more easily controlled, and at the end of the seventh week mental condition began to clear and symptoms entirely disappeared. *Result:* Improved.

RESULTS

The results* of treatment of these cases can be summarized as follows: Recovered, 8 (42.1 per cent); improved, 4 (21.0 per cent); unimproved, 7 (36.9 per cent).

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* Thanks are due Dr. B. O. Burch, who personally managed the insulin treatments, and the other members of the medical staff of the Livermore Sanitarium for their assistance in the examinations and reports.

ANALYSIS OF CASES

Our series includes some very old cases—one as long as eighteen years, and another ten years; but they were included in the group because the families were very anxious to have them treated. If we classify the cases in accordance with the duration of the psychosis, those under two years give a recovery percentage of 61.5. The designation "recovered" in our classification means the disappearance of symptoms, return of insight, and ability to resume the former mode of life. "Improved" means those patients whose symptoms have not entirely ceased, who lack true insight but are able to make a fair social adjustment.

RELAPSES

The recurrences in our series are only two, and these were during the course of treatment. In Case 7, after the first twelve weeks of treatment the patient was symptom-free, but after two weeks there was a relapse, so his treatment was immediately resumed and has been satisfactorily concluded. In Case 19, the patient had a distinct remission at the end of six weeks, and for a few days was entirely well; but then she relapsed over a week-end. This we thought might have been due to the fact that she did not receive the usual dose of insulin. Treatment in this case was continued, and there is improvement, although the case is not yet completed. Among the patients who have been discharged from the Sanitarium, there have been no relapses; and one case in particular has been doing well for a period of ten months. The reports from the European clinics, as summarized by Strecker,[4] give 23, 15, and 14 per cent, while the large group of cases of Müller gives only 6.5 per cent. In our series it is to be noted that two of the cases had a very long course of treatment—189 injections in Case 7, which improved; 114 in Case 8, with possible improvement; and no harmful results in either case.

EFFECT ON CENTRAL NERVOUS SYSTEM

The possibility of damage to the central nervous system by a treatment that causes, during coma, definite signs of cortical irritation, such as unconsciousness, convulsions, positive Babinski, etc., should be considered. In our cases, follow-up neurological examinations are negative, even in those cases having the largest number of treatments, such as Case 7 with 189 treatments. Another patient, Case 2, had an atypical Babinski, but no other signs of neural injury. Also, none of the patients in the unimproved group developed a more serious psychotic state, but were to some extent better.

DANGERS OF TREATMENT

The hazards of such a radical form of treatment must be recognized because of the possibility of death or permanent physical or mental injury. The one fatality in our series was probably due to insulin sensitiveness, causing coronary thrombosis. Sakel, in his early series of 104 cases, reports the treatment of three cases over sixty, one of whom showed cardiac complications, but treatment was resumed. Dr. I. C. Brill of Portland, in a personal communication, furnished the following extract, quoting from a recent book by Arthur M. Fishburg on heart failure: "It has been seen that insulin hypoglycemia increases the work of the heart and that the injection of insulin may be followed in individuals with coronary arteriosclerosis by anginal pain and perhaps coronary thrombosis."

The extensive application of hypoglycemia cannot be accomplished without the coöperation of the public, relatives, and medical profession. It behooves us, then, to select our patients with the utmost care, excluding those who are poor physical risks or who are so far deteriorated as to mitigate against recovery, in order not to discredit this form of therapy. Therefore, it may be well to limit the cases to those under the age of forty.

FURTHER DANGERS

The dangers during shock from aspiration of mucus, convulsions, or lack of time to terminate coma, are not very grave. There is, undoubtedly, a wide margin between deep coma and death, as illustrated by the case mentioned in an article by Cameron and Hoskins, where a delayed reaction was unrecognized and the patient lived forty-eight hours. Also, the margin of safety between reversible and irreversible cellular changes in the brain is sufficient to give considerable latitude. Moersch and Kernohan,[5] reporting on the autopsy of three patients dying of hypoglycemia, give the following: "There were acute degenerative changes in the brain cells, but it appeared that early acute degeneration could have been restored to normalcy and have assumed their normal function under favorable circumstances." The death rate in Europe of a large series of cases has only been one-half of one per cent.

DIFFERENTIAL DIAGNOSIS

The cases in our series are not all dementia praecox, as some were diagnosed by the staff as manic-depressive psychoses. This brings up the question of selection of patients. As we lack exact differential diagnostic methods, such as the laboratory tests in paresis, the limitation of hypoglycemic shock to dementia praecox is impracticable. In view of the uncertainties of diagnosis, it would seem that all functional psychoses would be suitable for hypoglycemic shock treatment, possibly with the exception of the manic-phase of the manic-depressive psychoses. Patients with the depressed phase might well be included, as they are so often confused with dementia praecox patients. The treatment is not a specific for dementia praecox, so a wider selection is justified, and probably definitely indicated. There is a possibility that the manic-depressive psychoses would have less predilection to relapse if they, too, were treated by hypoglycemia.

ACCESSORY TREATMENTS

The many other therapeutic aids ordinarily in use should not be denied our insulin patients. They require a well-balanced daily program, including recreation, exercise, and occupational therapy. These need to be prescribed in proper dosage and regulated in accordance with the rate of return of normal psychic functioning and emotional balance. It is our experience that psychotherapy—such as persuasion, suggestion, and therapeutic talks—is beneficial, but energetic probing of the mind must be avoided. This should be reserved until the patient is well advanced in a stage of convalescence, and not applied in the early days of treatment when the mental processes are only partially under conscious control.

THEORETICAL CONSIDERATIONS

As to the theoretical explanation of the therapeutic benefits, we have very little to offer. It may be that we are entering upon a new era in the treatment of mental patients, using the physiological approach, as pointed out in a paper by C. W. Mack[6] before this Society in 1935. Stimulation of brain cellular activity by the hypoglycemic state might well be the explanation of the improvement obtained. The only practical point in this connection to be seen in our series is that all recovered cases showed a gain in weight. This may mean an improvement in brain nutrition, due to an increase in the power of neuronic tissue to utilize sugar.

CONCLUSIONS

The final place in psychiatry of hypoglycemic-shock therapy will be determined in the years to come after the extent of recurrence has been studied. It may be that the ultimate result will show a more severe deteriorative process in patients with a malignant psychosis. A survey of the method to date, however, leads to the conclusion that it is a most fruitful form of treatment, and far surpasses anything at our command for the functional psychoses. The thought arises that hypoglycemic shock might well be applied to all new cases of this type received for treatment, either in private or public practice. The increased recovery rate in comparison with conservative programs of the past outweighs the risks, difficulties and expense. The state hospitals have such a large influx of patients that a great burden would fall upon the medical organizations of these institutions if all new patients were treated. The economic saving, however, by decreasing the total number of hospital days, would soon recompense the state for any additional expense in the acute services. The need for early treatment is apparent to all who have been engaged in this work, as the best results are obtained in the first few months of the illness.

SUMMARY

1. A review of the literature reveals a recovery rate of 40 to 50 per cent of patients treated with hypoglycemic shock.
2. The largest American report available compares favorably with the European statistics.
3. A series of nineteen cases is reported by the author, with 42.1 per cent recoveries.
4. The relapses in Europe are 6.5 to 23 per cent.
5. The treatment should not be limited to dementia praecox, but deserves wide application in all early functional psychoses.

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DISCUSSION

J. M. Nielsen, M.D. (727 West Seventh Street, Los Angeles).—Doctor Mack's paper is timely and well chosen. It is evident, from the number of treatments given to each patient, that he treats thoroughly. I am not in position to discuss the efficacy of the treatment in conditions other than schizophrenia, as we have confined our work to that group. Our group of three doctors has given thirty-six courses of insulin shock treatment to thirty patients (fifty shocks per treatment) and this means fewer shocks to each than Doctor Mack has given. On the other hand, we have given considerably larger single doses, as many have received 200 units daily, and some a great deal more, one 450 units per dose for a time.

As to complications, I note that Doctor Mack has had one death. This, however, was in a patient sixty years of age, so that is not strange. Our series of thirty cases includes only four over 36 years of age—39, 43, 48, and 49, respectively. We were more careful with these four than usual, and all survived; but there was no therapeutic benefit, except improvement in one of them. On the other hand, we have had considerable trouble with pulmonary complications. Three of our patients have had severe pulmonary edema and one, pulmonary embolus. The complication was very nearly fatal in each case. Those complications are our greatest fear; and a report of them will appear in the *Journal of the American Medical Association.* Prolonged coma, from which it was impossible to restore our patients for many hours (as long as thirty-three hours), has also occurred quite a number of times, but this is not dangerous unless simultaneous pulmonary edema ensues. So far we have had no fatality, but we may have one at any time.

I have arranged our therapeutic statistics to be comparable with those of Doctor Mack. Of our cases of schizophrenia (thirty cases) there were eighteen recent ones with recovery in twelve, improvement in four, and no results in two. We have treated twelve patients with disease of long standing (old cases), in which we did not obtain recovery in a single one, but improvement in six.

We think the method has come to stay as a permanent part of a psychiatrist's armamentarium, and we recommend it in the acute cases, especially those in young persons. In cases of long standing (more than a year), we tell the relatives that the percentage of recovery is very low, and hardly worth while unless the situation is desperate. We promise no results to anyone and we stress the dangers. We demand that the family take its part of the responsibility in any unfavorable outcome. The family must similarly be a unit in meeting the hazards emotionally. We assume the attitude that each treatment is very much like a surgical operation, and one must be prepared for all emergencies.

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E. W. Mullen, M.D. (Agnew State Hospital, Agnew). I have enjoyed Doctor Mack's paper on insulin shock therapy in dementia praecox very much. This is a subject which is receiving attention in the medical profession, and especially in that part of the profession which practices psychiatry.

Doctor Mack's approach is scientific and thorough. His conclusions are well founded. His findings indicate that, while a certain percentage of mental cases recover under the insulin shock treatment, some only improve and some do not improve. I think he might have added that in some cases their condition becomes more aggravated. Therefore, the treatment is not a specific. However, any treatment that gives relief in some cases should be given our honest and earnest attention.

Perhaps the name "insulin shock" is not the best name that we could have used in this treatment. It is not a true condition of shock as we see in surgery, etc.; it is more of a toxic condition. Perhaps it is really more of a mental shock than a physical. This, however, is not important if you get good results.

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Samuel D. Ingham, M.D. (727 West Seventh Street, Los Angeles).—The authors have given us a practical review of the status of insulin shock therapy, as reported from various clinics, as well as their own results. Their experience has been in close accord with most of the work reported, and indicates that the insulin treatment of dementia praecox is the most efficient means of treating this condition.

It is to be emphasized that success of this treatment depends largely upon the technique of its administration and, therefore, upon the experience and judgment of those who are using it. The best results are obtained when insulin shock is carried to the ultimate degree consistent with a reasonable margin of safety. It is, therefore, important to be on the alert for danger symptoms and to be ready with emergency treatment. No satisfactory theory has been offered to explain benefits derived from the insulin treatment of schizophrenia, although several have been proposed.

It is of interest to note the marked improvement in the physical condition of patients which occurs simultaneously with the improvement of the mental condition. This includes a gain in weight, improved digestion, better circulation and vasomotor stability, as well as general improvement in vegetative functions.

I think that all who have had a comprehensive experience with this form of treatment can subscribe to the conclusions of the authors expressed in their summary.

CONGENITAL RENAL ANOMALIES*

WITH SPECIAL REFERENCE TO HORSESHOE KIDNEY

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Hollywood

Discussion *by Robert V. Day, M.D., Los Angeles; Benjamin H. Hager, M.D., Los Angeles; William E. Stevens, M.D., San Francisco.*

DOUBLE kidneys, reduplication of pelves and ureters are the most frequent anomalies of the upper urinary tract. Next in frequency is horseshoe kidney. In general, this interesting renal mass may be defined as a symmetrical, semicircular fusion of the two kidneys across the vertebral column by a bridge or isthmus which, even without concomitant disease or gross pathology, produces a clinical syndrome called horseshoe kidney disease; an entity due to pressure, which is characterized by indefinite epigastric or umbilical pain, intestinal and urinary stagnation.

CLASSIFICATION

In order to institute better clinical and surgical management of horseshoe kidney, Gerard, and later Gutierrez, have classified the subject into symmetric and asymmetric groups. The symmetric division refers to fusion by a bridge of renal or fibrous tissue of the two organs at the lower poles with concavity upward, or fusion of the upper poles with concavity downward. This organ rests astride the vertebral column. The asymmetric type refers to irregularities in shape, location, and position. This entity is less common and the individual types accordingly are termed unilateral fused kidney, L-shaped renal fusion, fusion en glatte or disc form, sigmoid fusion, fusion en masse, and fusion without form.

INCIDENCE

With the advent of urography, the incidence of this anomaly has markedly increased. Various averages from the statistics of several necropsy surgeons before the introduction of pyelography, fix the rate to about 1:1000; however, with this method of urologic diagnosis the frequency has been increased to about 1:400, and even more recently the ratio is reported to be 1:200 pyelograms. In 68,989 necropsies reported by Carlier and Gerard, there were eighty horseshoe kidneys, or 1:862; Kuster, 1:1100; Davidsohn, 1:1000; Judd, Braasch and Scholl, 17:2424 operations on the kidney; Bettez, 1:715; Guizzetti and Pariset, 1:1142; Marynski, 1:683; Naumann, 1:600; Jeck, 1:643; Thompson, 19:12,888 (1:671); Motzfield, 92:73,489 (1:710); Lipshutz and Hoffman, 105:70,502 (1:671); Legueu and Papin, 1:600.

EARLY LITERATURE

In the annals of medical history, from the ancient down to modern times, one can find a fascinating story of this subject. First, the ancient anatomist and post-mortem surgeon reported this "monstrosity"; then, with the commencement of kidney surgery late in the nineteenth century, the anomaly was discovered during abdominal exploration for tumor; and, finally, this history continues on to an era of clinical diagnosis by physical examination, and more recently, to conclusive diagnosis by retrograde or intravenous urography.

Early in embryonic life it is an established fact the pronephros, mesonephros, and metanephros arise from both entoderm and mesoderm. The pronephros degenerates early and is considered rudimentary in character; the mesonephros is important during embryonic life, and its remnants enter into formation of the genital tract; and, lastly, the metanephros establishes itself as the permanent kidney. The renal buds appear behind and at the lower end of the mesonephros or Wolffian duct during the fourth week and progressively change their shape and position; hence, the opportunity for anomalous development between the fifth and seventh week. These anlagen arise on a level with the second sacral vertebra below the umbilical arteries and aortic bifurcation, and migrate upward. This vascular mechanical obstruction, according to several writers, may impede the ascent and rotation and permit fusion to take place.

SYMMETRICAL FORM

The most common or symmetrical form of horseshoe kidney is a semicircular mass of renal substance whose concavity is upward, and united at the lower poles (90 to 95 per cent) by a bridge or isthmus of renal or fibrous tissue which crosses the spinal column. The renal parenchyma usually retains some marks of fetal lobulation, and the right and left halves are seldom exact in position or shape. The asymmetrical organ presents a remarkable tendency to dystopia.

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* Read before the Urology Section of the California Medical Association at the sixty-seventh annual session, Pasadena, May 9-12, 1938.

The isthmus connecting the lower poles is in close apposition to the surrounding structures, namely, (*a*) posteriorly, the inferior vena cava, abdominal aorta, solar plexus and vasovisceral branches, the great lymphatic reservoir, and the spine; (*b*) anteriorly, the parietal peritoneum and intra-abdominal viscera. Usually the bridge is low at the umbilical level, the aortic bifurcation, or level of the fourth to fifth lumbar vertebrae.

The pelves, usually two in number, are generally anterior to the blood supply, incompletely rotated, and extend on to multiform calices in the reverse position. The latter frequently cross a portion of the spine. The ureters cross the isthmus and connect each pelvis to the bladder. If fusion of the upper poles (5 to 10 per cent) is present, the ureters usually arise from the upper portion of the kidney mass and do not cross the isthmus.

In collected studies from the literature, from four to six renal arteries supply and support the median and two lateral sections; however, anomalies predominate. The solar plexus, splanchnic nerve, sympathetic and parasympathetic nerves, phrenic nerves, and other regional interanastomoses enervate the kidney. The lymphatics are multiple and run parallel to the retroperitoneal vessels. In close proximity is the cisternal chyli.

DIAGNOSIS

In clinical practice the diagnosis of horseshoe kidney is made usually after the urine has become infected. Pressure of the isthmus on the adjacent structures produces extensive nervous and circulatory phenomena. Then stasis in the renal pelves, due to ureteropelvic juncture obstruction, high ureteral implantation, and structural dependency, initiates the sequelae of infection.

Horseshoe kidneys undergo the same pathologic lesions as normal kidneys; however, because of the predominating factor of stasis, hydronephrosis, pyelonephritis, pyonephrosis, and calculous disease are common sequelae. Cases of tuberculosis, neoplasm (parenchymal or pelvic), polycystic disease, and chronic diffuse nephritis, have been reported.

The clinical history and physical examination are seldom sufficiently significant to suggest the possibility of a tentative diagnosis of horseshoe kidney. Gutierrez's horseshoe kidney syndrome, consisting of umbilical or epigastric pain, chronic constipation, and urinary findings, is worthy of emphasis by repetition. In the thin patient an abdominal mass and isthmus may be palpated. Israel and others have stated that "the surgeon must bear in mind the possibility of such a congenital kidney malformation." Symptoms, signs, and findings such as, or of, renal colic, nephritis, pyelonephritis, uremia, and chronic cystitis, are to be considered.

The conclusive diagnosis of horseshoe kidney has been reduced to simple mechanical technique since the era of cystoscopy and urography. Routine urologic study, consisting of medical history, physical examination, urinalysis, blood chemistry, phenolsulphonephthalein test, roentgenography, cystoscopy, ureteral catheterization, differential renal function tests with phenolsulphonephthalein, and retrograde bilateral pyelography or intravenous urography without cystoscopy, adequately provides a complete diagnostic armamentarium. The horseshoe kidney pyelographic triangle of Gutierrez is fascinating and seems to be pathognomonic; at least practical in its application.

Certain roentgenological and pyelographic findings, such as delineation of renal poles of both kidneys, close proximity to vertebral column, obliteration of psoas outline, renal calculi in transverse position near midline, "flower vase" figure of ureteral catheters, inversion and rotation of pelves, inversion of lower calices and directed medialward, bizarre pelves near spine, "bottle neck" ureteropelvic appearance, "minimum lower angle of horseshoe kidney triangle," if critically employed should establish conclusively the diagnosis of this anomaly.

TREATMENT

The treatment of horseshoe kidney varies with each individual case, and is particularly dependent upon the existing pathologic lesions. Indwelling ureteral catheter drainage is necessary in the presence of acute manifestations. Intermittent drainage may be sufficient as a temporary procedure in chronic urinary stasis. In infected hydronephrosis, pyonephrosis, tuberculosis, or neoplasm, involving half of the renal mass and in the presence of a normal half, resection (heminephrectomy) is a rational procedure. The surgical technique is comparable to that carried out in similar pathologic processes in a normally formed kidney. Transperitoneal anterior as well as retroperitoneal lateral and anterolateral approaches have been recommended and practiced. The transperitoneal anterior incision simplifies the operation. During surgery in infected cases, care should be exercised to avoid peritoneal contamination, and with tight peritoneal closure a retroperitoneal stab wound and drain are recommended. Conservation of renal substance is even more axiomatic in dealing with this congenital anatomopathologic entity. Pelviolithotomy should be stressed more seriously than resection, because of the potential danger of subsequent disease of the opposite parenchyma or pelvis. The literature attests to the rational of symphysiotomy and nephropexy in "chronic cases of horseshoe kidney disease with clinical symptoms."

To demonstrate several of the above ideas, which are in no way original with us, we give below the clinical history of one recent case of horseshoe kidney which we personally observed, and our surgical technique will be shown in motion pictures in color.

REPORT OF CASE

History.—A white female, aged 56 years, was admitted to the hospital on May 10, 1937. She complained of blood in the urine, dull pain and a sensation of heaviness in the upper and right side of the abdomen, extending through to the back, especially for the past four months. The patient stated that passage of the uniformly bloody specimen of urine was without bladder discomfort. The familial and early personal history were not relevant.

Examination.—The examination revealed a very well-nourished female, who was alert, coöperative, and in no acute distress. Temperature was 98.6 degrees; pulse 78. The abdomen was characterized by a hard, slightly moveable mass about the size of a large grapefruit, located in the epigastrium, but more prominent just to the right of the

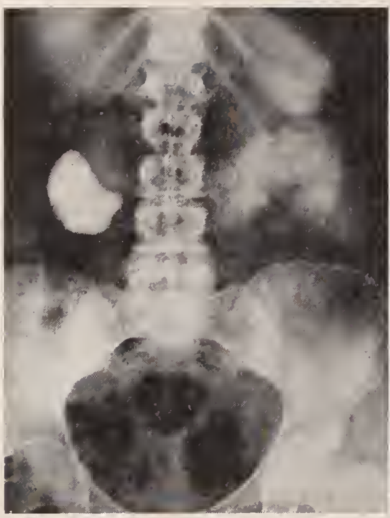

Fig. 1

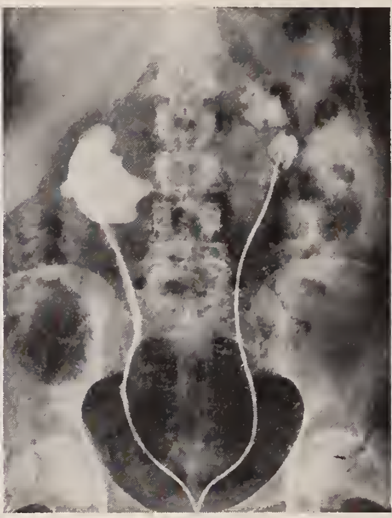

Fig. 2

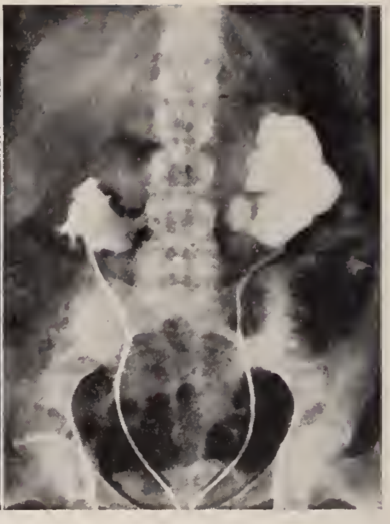

Fig. 3

Fig. 1.—Antero-posterior roentgenogram of the kidney, ureter, and bladder area, showing a large calculus near the spine and indistinct delineation of the kidney poles.

Fig. 2.—Bilateral pyelograms showing calculus in right kidney pelvis; left pelvic dilatation although incompletely filled; pelves near spine, and improperly rotated; "flower vase" figure of ureteral catheters; 22 degree "minimum lower angle of horseshoe kidney triangle."

Fig. 3.—Postoperative (11 months) bilateral pyelograms showing satisfactory anomalous kidney pelvis and enormously dilated left kidney pelvis.

midline. A very hard, protruding irregularity (calculi), particularly noticeable upon inspection and palpation, was localized to the right of and somewhat above the umbilicus.

The urine was suggestively bloody grossly and contained many red blood cells, pus cells, and Gram-positive cocci in clumps. Blood non-protein nitrogen, 25 milligrams per 100 cubic centimeters. One cubic centimeter of phenolsulphonephthalein given intravenously appeared in three and three-quarter minutes; 45 per cent and 10 per cent recovered in the first and second thirty-minute periods, respectively. Blood Wassermann and Kahn tests were reported negative. Hemoglobin, 85 per cent; red blood cells, 5,250,000; white blood cells, 9,600; 69 per cent polymorphonuclear leukocytes.

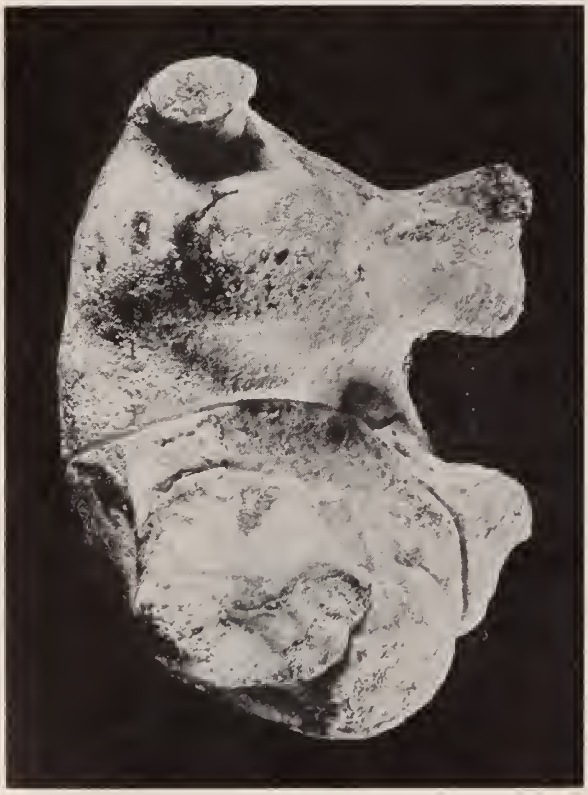

Fig. 4.—Surgical specimen, staghorn faceted calculus reassembled.

Kidney, ureter, and bladder roentgenogram (Figure 1) presented a large staghorn calculus near the spine, on the right side at the level of the third and fourth lumbar vertebrae. Several small opacities were reported in the corresponding area on the opposite side. The renal silhouettes were indistinct; however, the lateral borders of a mass of tissue seemed to be closer than normal to the midline.

Cystoscopic examination presented evidence of a mild cystitis. The ureters were readily catheterized and specimens of urine obtained from the renal pelves showed the following: Right—many pus cells and Gram-positive cocci in clumps; left—few pus cells and Gram-positive cocci. Differential renal function test, using one cubic centimeter of phenolsulphonephthalein intravenously showed: Right—appearance time eight minutes, 5 per cent excreted in twenty minutes; left—appearance time five minutes, 15 per cent excreted in twenty minutes.

Other roentgenograms, including bilateral pyelograms (Figure 2), disclosed the following findings: (*a*) Large right staghorn renal calculus near the vertebral column; (*b*) small densities (?) in the corresponding area of the opposite side; (*c*) "flower vase" figure of the ureteral catheters; (*d*) inversion and rotation of bizarre renal pelves; (*e*) inversion of lower calices directed medialward; (*f*) bilateral pelvic dilatation, especially the left; (*g*) "bottle neck" ureteral position; and (*h*) 22 degree lower angle of horseshoe kidney triangle. The diagnosis of horseshoe kidney with calculous disease was definitely established. Surgical removal of the calculi in the right renal pelvis was recommended and accepted.

Operation.—(May 25, 1937, recorded in motion pictures in color.) Under inhalation anesthesia, an incision was made parallel to and one and one-half inches to the right of the abdominal midline, commencing high in the right epigastric area and extending a few inches below the umbilicus. After opening the peritoneum the intra-abdominal contents were readily displaced to expose the horseshoe kidney. Incidentally, a 2.5 centimeter calculus was discovered in, but not removed from, the gall-bladder. The posterior peritoneum was incised longitudinally and the anomalous kidney, particularly its right half and isthmus, was exposed. Fusion of the upper poles was readily discernible. A moderately dilated, highly implanted right ureter and thickened, distended anterior pelvis were found. After opening the renal pelvis several large faceted calculi, forming a complete silhouette of the pelvis, were removed

(Figure 4). Due to the thickness of the pelvic wall, it was possible to make a substantial repair. A Penrose drain was directed retroperitoneally to the costo-iliac space and retrieved externally through a small stab wound. Each peritoneal incision was closed tightly without drainage, and the remainder of the abdominal wall was repaired with chromic catgut and skin dermal sutures.

Postoperative Course.—At no time did the temperature exceed 100.4 degrees, or the pulse 100 per minute. These were normal on the fifth day. The abdominal wound healed by primary union and only a slight amount of serous drainage came from the stab wound. The abdomen remained undistended and peristalsis was active. The patient was discharged from the hospital on the twenty-second, postoperative day, ambulatory and apparently in good health.

Unfortunately, this patient did not keep her clinic appointment and was not examined until January 1, 1938 (seven months later). At that time she complained of severe aching in the left abdomen and costo-iliac space. Examination disclosed the following: Well-healed surgical scars; tenderness in left abdomen and costo-iliac space. Temperature 98.6; pulse 80; respiration 20. Bladder urine: many pus cells and Gram-negative bacilli. Phenosulphonephthalein test: Appearance time four minutes, 50 per cent first half-hour, 15 per cent second half-hour. Blood nonprotein nitrogen, 23 milligrams; kidney, ureter, and bladder roentgenograms negative for calculi. Cystoscopic study, ureteral catheterization, and bilateral pyelography presented mild cystitis, large irregular, left hydronephrosis, and sharply defined minor calices of the right pelvis. Urine from the right pelvis was negative for pus and bacteria; however, the left one contained many pus cells and myriads of Gram-negative bacilli. Phenolsulphonephthalein, one cubic centimeter intravenously, appeared in 5 minutes and 11 minutes from the right and left pelves, respectively, and the right excreted 22 per cent in 20 minutes; the left 2½ per cent. This study substantiated a diagnosis of left infected hydronephrosis. The patient responded with left ureteral dilatation and lavage of the kidney pelvis.

Again the patient was discharged from the hospital; however, one of us (S. K. B.) recently (April 14, 1938), subjected her to another complete kidney study. The essential points of interest are: No demonstrable urinary calculi; only a trace of function from the left pelvis; right pelvic urine without pus or bacteria; left, "loaded" with pus and Gram-negative bacilli and, according to the pyelogram, consistent with a far-advanced hydronephrosis (Figure 3). At this writing no further treatment has been instituted, since the patient has established residence in a distant rural community.

CONCLUSIONS

1. A case of horseshoe kidney (fusion of the upper poles) with calculous disease is reported; its clinical history given and the surgical treatment (transperitoneal pelviolithotomy) recorded through motion picture in color.

2. Urinary stasis, due to anomalous pelves and ureteropelvic juncture obstruction, is the main causative factor of associated pathology.

3. Roentgenographic procedures, especially bilateral pyelography, offer a conclusive diagnosis.

4. Surgical technique is comparable to that carried out in similar pathologic processes in a normally formed kidney. We, in this instance, chose the transperitoneal approach.

5. Conservation of kidney substance is even more axiomatic in dealing surgically with this congenital entity because of the potential danger of subsequent disease of the corresponding parenchyma and pelvis.

1680 North Vine Street.

DISCUSSION

Robert V. Day, M. D. (1911 Wilshire Boulevard, Los Angeles).—With the advent of excretion urography, fewer cases of horseshoe kidney are overlooked—as stated by the authors. But even greater emphasis should be placed on the careful study and correct interpretation of urograms obtained both by the intravenous and retrograde methods. The clinical syndrome in itself is highly suggestive, and calls for adequate urologic investigation. In their modesty, and apparent attempt not to appear dogmatic, I fear the authors have not sufficiently stressed these points, although the case history shows how painstakingly all these were carried out. Excretion urography is of more diagnostic import in horseshoe than in other forms of upper urinary-tract anomalies, for the reason that in so many of the other anomalies of the kidney and ureter one segment is apt to be entirely functionless and no radio-opaque agent is excreted in this segment.

At this point it might not be amiss to state that when one is too eager to discover rare anomalies he is apt never to find them. But if we strive with wide-open minds to make correct and total urologic diagnosis in each and every case as they are presented—simply assaying the patient for whatever pathologic condition, lesion or disease that he may have—the rare anomalies will seldom be overlooked. This does not mean, however, that we should carry out routine major urologic diagnostic procedures which the clinical history, subjective symptoms and simple subjective findings do not warrant. Individualizing of cases, and their careful study, supply the clues which indicate the kind and extent of urologic investigation that should be carried out.

The authors' case is an interesting one from several standpoints. First of all, the fusion was at the upper pole—quite rare.

From the clinical standpoint, one is bound to note the wise conservativeness of the authors in the management of this case. Moreover, the practical results attest this. Each case is apt to present a specific problem, and perhaps their next case of horseshoe kidney would call for a quite different surgical procedure, such as, for example, division of the isthmus and unilateral nephropexy.

I wish to commend the authors on their clear, succinct presentation of a rare and interesting case history, and their sound judgment in its management.

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Benjamin H. Hager, M.D. (1136 West Sixth Street, Los Angeles).—Doctors Rusche and Bacon have presented a most unusual case of congenital anomaly in which a huge stone could be readily palpated through the abdominal wall. This unquestionably was the factor which decided the transperitoneal approach, a very courageous one in the presence of kidney infection. It has been established that horseshoe kidneys, in the absence of pathology, often give rise to a characteristic syndrome. This anomaly likewise is prone to develop symptoms arising from interference with urinary drainage—hydronephrosis, stone and infection being rather common complications. More lasting benefits are apt to follow surgery if attention to stasis is instituted. I have been very much impressed with the teachings and results of Doctor Foley of St. Paul, who makes it a practice, when feasible, to sever the communicating isthmus and perform a nephropexy at one sitting. This is followed, at a later date, by nephropexy of the remaining half. His records show an enviable result from the standpoint of complete relief of symptoms.

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William E. Stevens, M.D. (490 Post Street, San Francisco).—In reviewing the literature some years ago I found that, in the combined reports of 148,329 autopsies, horseshoe kidneys were present in 198 or once in 749 cases. As Doctors Rusche and Bacon have stated, they are found more often clinically since the advent of pyelography.

In the horseshoe kidneys that have come under my observation the most frequent symptom has been pain or discomfort in the abdomen, usually increased by exercise and relieved by rest in bed. A smooth, apparently oval mass was occasionally detected on palpation. The isthmus, unless composed of fibrous tissue, will often be more clearly outlined following excretory rather than by retrograde pyelography. Concomitant abnormalities of the genital organs are common, and horseshoe kidneys are not infrequently confused with lesions of the pelvic organs in the female. Pyelography is always indicated in the presence of an abdominal or pelvic mass of uncertain origin.

I wish to present brief histories and lantern slides of three cases:

Case 1. A young married woman complained of pain in the right groin (worse during menstruation), frequent urination and a sensation as if "something was pressing on the bladder." The characteristic pain was reproduced during vaginal palpation. The urine was negative. Pyeloureterography revealed a horseshoe kidney, and it was thought her symptoms were partly due to this anomaly. These disappeared, however, following the removal of infected tubes and a cystic right ovary. Many horseshoe kidneys exist without symptoms. The urine was negative in two of these cases I am reporting.

Case 2. A married woman, sixty-eight years of age, complained of a burning pain in the entire abdomen and frequent urination. Her urine contained numerous pus cells. Both pelvic and urinary-tract pathology were suspected. Pyelography revealed a horseshoe kidney. The isthmus is unusually well outlined in this case. The patient refused further investigation.

Case 3. Although previously reported, I am again presenting the following unique case, as it is interesting in connection with Doctors Rusche and Bacon's paper. The patient, a young woman, twenty-three years of age, complained of lower lumbar backache, worse during menstruation, and relieved by rest in bed. She also suffered from obstinate chronic constipation and malaise. The urine was negative. Pelvic and gastro-intestinal examinations were likewise negative. A firm oval smooth abdominal mass, the size of a large hen's egg, could be palpated a little to the right of the midline above the umbilicus in this case. Forceful aortic pulsation could be detected over the inner half of this mass. Cystoscope was negative and the ureters were easily catheterized. Kidney function was slightly increased on the right side. A pyelogram of the right kidney showed marked overlapping of the calices. Unfortunately, the patient, a very nervous individual, refused further cystoscopic or pyelographic investigation. Exploratory laparotomy revealed a somewhat kidney-shaped mass with a pelvis lying transversely across the fifth lumbar vertebra. A third ureter ascended about 1.5 centimeters from the center of this mass, turning to the right and descending about one centimeter, where it joined the right ureter. The mass was fused at both extremities with the right and left kidneys, respectively. Another unusual feature in this case is the normal position of the left kidney. Both kidneys are almost always lower in fusion of the horseshoe type. The patient's symptoms improved and eventually disappeared, following the removal of an appendix which showed evidence of previous inflammation and a cystic right ovary. Should this be classified as a fused third kidney or a horseshoe kidney with three ureters?

Doctors Rusche and Bacon's paper has been most interesting. They are to be congratulated on both their surgical conservatism and their excellent motion picture. According to statistics, operative mortality is increased following operation on horseshoe kidneys.

SOBISMINOL: ITS ORAL ADMINISTRATION*

CLINICAL RESPONSES AND ADVANTAGES IN FIVE LUETIC PATIENTS IN PRIVATE PRACTICE

By WILLARD E. KAY, M.D.
AND
JOHN W. FRICKE, M.D.
San Francisco

SOBISMINOL is a soft mass in capsules, each capsule containing equivalents of 0.2 gram sodium bismuthate, 0.4 gram tri-isopropanolamin, and 0.1 gram propylene glycol. The bismuth content is about 70 per cent, equivalent to about 0.14 gram of bismuth metal in each capsule. The reaction product has not yet been identified chemically, but appears to be a complex organic bismuth compound with unique properties. The description of the product and its actions, absorption, excretion, toxicity, etc., have been reported in several papers from Doctor Hanzlik's department,[1] and the following brief summary of the product will suffice here: High stability in body fluids, tissues, weak acids and alkalies; readily and adequately absorbed from the alimentary canal; bismuth distributed to all tissues; excreted in urine; low toxicity, but has a fatal dose in animals; tolerance good; potent antisyphilitic actions in experimental and clinical syphilis in all stages. A solution can also be used intramuscularly. The gastro-intestinal absorption, urinary excretion, tolerance, and high antisyphilitic potency of oral sobisminol in patients have been confirmed by Cole, Sollmann, and Henderson of Cleveland,[2] who feel that sobisminol is the most potent bismuth compound of all bismuth compounds by any method of administration. Sobisminol is the only compound of several proposed for oral administration that is really adequately absorbed and effective in antisyphilitic treatment. The favorable reports on sobisminol justified the clinical trial we have given it. Brief protocols of our cases follow.

REPORT OF CASES

CASE 1.—Mr. A. W., age 83, a capitalist, first seen at his home on July 2, 1935, complained of agonizing pains in the lumbar and lower dorsal regions (which had come on three months prior, following a prostatic resection), an incontinence and nocturia as often as twelve times per night. The pains were especially prone to occur at night while the patient was in bed and particularly when changing position, and were described as lightning and knife-like, radiating from the lower dorsal spine region to the mid-abdominal region.

Physical findings were: an old chronic antrum infection, a chronic bronchitis with bronchiectasis and emphysema, an enlarged heart (chiefly left ventricular hypertrophy), a widened and thickened aorta with especially supravalvular widening, an accentuated aortic second with a loud systolic blow, moderately thickened peripheral blood vessels, pulse rate 68, blood pressure 200/80 in both arms, a palpable liver but not tender, marked tenderness over the descending colon (x-ray later revealed chronic diverticulosis), moderately atrophic gonads, slightly hypertrophied and firm prostate, and some lordosis, and scoliosis and tenderness of the lumbar and lower dorsal spine. Tendon reflexes of lower extremities could not be obtained. No Babinski or Oppenheim. Romberg was negative, no past pointing. Motor force was good. No sensory disturbances. The pupils were regular in outline, myotic, but reacted sluggishly to light. The blood Wassermann, Kline, and Kahn were three plus. No spinal puncture was done because of the patient's age. Inquiry from his genito-urinary specialists disclosed the fact that he had, in years past, been extensively treated with neoarsphenamin, which always gave him a severe reaction, with temperature reaching as high as 102 and 104 degrees, and mercury, intramuscularly, topically, and orally.

Iodobismitol with saligenins was exhibited intramuscularly every five to seven days, which brought about prompt but not complete relief from the pain. After twenty-four injections the Wassermann, Kahn, and Kline, however, did not improve. At this time, April, 1936, the patient decided to take a trip through the Panama Canal to New York, and it was then that sobisminol was administered by mouth. Two capsules of sobisminol were taken each day for approximately fourteen days, at the end of which time he would usually manifest symptoms of intolerance, characterized by weakness, depression, sleeplessness, slight diarrhea, and frequent urination. Upon the earliest signs of saturation the patient would discontinue the capsules for two or three days, and then again feel quite well. After taking the capsules for one month—approximately fifty-six capsules (7.8 grams of bismuth)—the pains in his back disappeared entirely, and the nocturia decreased to an average of three times a night. On his return, two months later, blood Wassermann was taken and sent to Doctor Wyckoff, Stanford Clinical Laboratory, which was negative in all three antigens. The Hinton and Kline tests, however, were positive, three plus.

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* Through the courtesy and kindness of Dr. P. J. Hanzlik, of the Stanford University School of Medicine, San Francisco, and the Cutter Laboratories, Berkeley, we have had the privilege of treating five cases of syphilis orally with sobisminol in our private practice. The clinical responses in all five cases has been so satisfactory that it seems warranted to publish them.

Mr. A. W. passed away at the age of eighty-eight on March 21, 1938, of pneumonia, working hard up to the onset of his illness of five days' duration. He had been symptomless as far as his lues was concerned, and, additionally, rather frequent attacks of angina pectoris had disappeared altogether, and a brownish-colored skin had cleared and appeared normal to him. Mr. A. W. used approximately 1,200 capsules of sobisminol over a period of about twenty-one months, or an equivalent to 168 grams of bismuth ion. His serology had changed from a three plus Kline, Kahn, and Wassermann to a two plus Kline, one plus Kahn, and a negative Wassermann.

His serological findings are tabulated as follows:

July 10, 1935	Kahn 3 plus Kline 3 plus Wassermann 3 plus
January 17, 1936	Kahn 4 plus Kline 4 plus Wassermann 4 plus

Sobisminol—three capsules daily:

April 17, 1936	Kahn 4 plus Kline 4 plus Wassermann 4 plus

Return from two months' trip:

June 26, 1936	Kline 3 plus Kahn 3 plus Wassermann negative
July 21, 1936	Kline 3 plus Wassermann negative
October 26, 1936	Kline 3 plus
December 11, 1936	Kline 3 plus
March 4, 1937	Kahn 3 plus Wassermann negative
October 13, 1937	Kahn 4 plus Kline 3 plus Wassermann negative
January 19, 1938	Kahn 2 plus Kline 1 plus Wassermann negative

* * *

Case 2.—Mrs. E. R., age 66, was first seen on September 17, 1937, with a "sore" in her mouth, which failed to heal in five weeks, as well as a "sore" on the base of the left index finger which had healed very slowly. A history of lues, contracted eleven years ago (1926), was obtained which had been intensively treated for two years at that time.

Physical examination only revealed an accentuated aortic second sound and a moderately widened aorta, the latter borne out on fluoroscopic examination. The neurologic examination was essentially negative.

Laboratory findings were as follows:

Urine: Clear; acid; specific gravity of 1.028; sugar 3 plus; albumin, negative; white blood cells, 3.4 per high dry field.

Blood: Hemoglobin, 80 per cent, 13.25 grams; red blood cells, 4.38 million; white blood cells, 8,600; differential—neutrophils 55, lymphocytes 38, endotheliocytes 5, eosinophils 2.

Serology: Kahn, 3 plus; Kline, 3 plus; Wassermann negative.

Chemistry: Blood sugar, 250 milligrams per 100 cubic centimeters of blood.

The patient was placed on a diabetic regimen, and sobisminol, one capsule three times daily, was administered. Twelve days following the exhibition of the capsules (thirty-six capsules equivalent to 50 grams bismuth ion) the oral mucosa had healed completely. Approximately 1,000 capsules of sobisminol, 140 grams of bismuth ion, have been taken by her, and at no time have they caused any deleterious effects. The blood picture chronologically is as follows:

November 3, 1937	Blood sugar, fasting specimen, 200 milligrams per 100 cubic centimeters Wassermann negative Kline negative Kahn negative
January 12, 1938	Blood sugar, fasting specimen, 136 milligrams Serology negative
April 12, 1938	Blood sugar, fasting specimen, 134 milligrams Serology negative
July 14, 1938	Serology negative

* * *

Case 3.—Mr. M. O., age 34, on November 9, 1937, complained of a sudden ptosis of the left upper eyelid and continuous headache. Physical examination revealed, in addition to the ptosis, an external strabismus, the eye being directed a little downward, a slight protrusion of the eyeball, a mydriasis, and a loss of accommodation. No diplopia was determined. The general physical examination was essentially negative. The blood serum, Kline and Wassermann, were four plus and the spinal fluid revealed a cell count of five, a trace of globulin and sugar, a four plus Wassermann, and a colloidal gold: 234321000.

The patient was placed on one capsule of sobisminol three times a day, and has taken them continuously to the present time. In July, 1938, he wrote that the eye had practically returned to normalcy, that the headaches had disappeared six weeks after the exhibition of the drug, and that he at no time showed any evidence of intolerance, having ingested a little over 700 capsules. This clinical response was confirmed by the patient's local doctor in Nevada. He has promised to return for reëxamination before the end of the year.

* * *

Case 4.—Mr. W. F., age 50, a miner in an isolated town in Nevada, came to us in July, 1934, suffering from severe coughing spells, shortness of breath, weakness, and loss of weight. Examination disclosed much density throughout the chest, particularly in the left upper lobe, and in the lower posterior part of the right upper lobe and the upper posterior part of the right lower lobe, a large area of compact density measuring almost five centimeters in diameter. Our impression was that he had a combination of pneumonoconiosis and tuberculosis with encapsulated fluid or pneumonitis. No fever was present, and repeated sputum investigations failed to uncover acid-fast organisms. Wassermann and Kahn were both four plus. Antiluetic treatment was instituted. He received two injections of neoarsphenamin, .15 grams and 3 grams, respectively. Following the second injection he developed a scarlatiniform rash with fever. He then received eighteen injections of iodobismitol with saligenins. A radiograph of the lung, taken on November 21, 1934, revealed a marked amount of absorption of the dense area already described, which was so striking after the antiluetic therapy that we thought we were dealing with syphilis of the lung plus pneumonoconiosis.

Because of urgent business reasons the patient left for home feeling much improved. A simple cough syrup was prescribed, to be taken when necessary, and lipiodid tablets at periodical intervals. Since then he has come to us for treatment on eight different occasions. His last visit was on February 25, 1938. He still coughed a good deal, especially in the morning; was somewhat short of breath, tired easily, and was underweight. Blood serum revealed Kahn 3 plus, Kline 3 plus, and Wassermann 2 plus. Antiluetic treatment was again exhibited, commencing with neoarsphenamin, .15 gram intravenously, which was followed almost immediately by a severe and almost fatal nitriod reaction with edema, circulatory and respiratory collapse. He then was placed on the sobisminol capsules, one three times a day, and an ample supply was given him to take home, which he gratefully received as a substitute for the injections.

He writes that he has been so busy and has felt so well, *e. g.*, without cough, sputum, and with a general feeling of well-being and gain in weight, that he has delayed his return visit, but will do so in January, 1939. This marked improvement leads us to believe all the more that syphilis of the lung complicates the pneumonoconiosis. We might feel that the iodin component of the sobisminol, exerting salutary effect on a pneumonoconiotic lung, was responsible had it not been for its (iodin) exhibition previously over a long period of time. He has taken approximately 800 capsules (112 grams of bismuth ion), and has never had any ill effects. We look forward with interest to our findings on his next visit.

* * *

Case 5.—Mr. J. G., age 25, a printer, complained of severe headaches, confined to the top of his head, which usually forced him to bed. No apparent reason for them could be given by the patient. In the course of a routine examination a three plus Kline was obtained, but no evidence of lead poisoning. The patient denied ever having an acute infection, nor could he give any information so far as his family was concerned, since both his parents died when he was but nine years of age. A careful physical and neurologic examination was made, revealing no evidence of lues, nor could any evidence of hereditary stigmata of syphilis be obtained by careful investigation of teeth, etc. Blood sent to the state laboratory was reported as a three plus Kline and a four plus Kahn, the Wassermann being negative. Stanford Medical School clinical laboratories reported a positive Hinton test and a negative Wassermann, which was slow to clear.

The patient underwent a submucous resection and was relieved of his headaches entirely. Following twelve weekly intramuscular injections of Fraisse's Quinine Iodo-Bismuthate, 0.2 grams, all tests—Kline, Kahn, and Wassermann—were negative, both in our own laboratory and the State of California laboratory. A spinal puncture, too, was negative. Six months later blood again was checked, showing Kline three plus and Wassermann negative in our own laboratory, and Kahn four plus and Wassermann negative in another laboratory.

The apparently conflicting serum reactions were highly interesting, though disconcerting. Several clinical pathologists, as well as Dr. B. S. Kline, were consulted. On two different occasions whole clotted blood, collected under sterile precautions, was sent to Doctor Kline, and the blood on both occasions gave the following results in the slide tests: Diagnostic, plus, minus—doubtful; exclusion, four plus—strongly positive. Doctor Kline was of the opinion that lues could not be excluded because of the persistence of at least weakly positive reactions with the flocculation tests, and did not believe that the four negative Wassermann reactions were as significant as the five weakly positive flocculation reactions, because the latter tests were more sensitive.

The patient was placed on sobisminol capsules, two capsules three times a day, but after twenty-five days' administration the patient became nauseated, so a week's rest was ordered. Since then Mr. J. G. has adjusted the dosage to two capsules before breakfast, and finds he has no symptoms of intolerance whatsoever. His last serologic report on December 8, 1938, both in our laboratory and another laboratory, was negative throughout. A total of 500 capsules had been taken.

Serologic findings were as follows:

July 23, 1936	Kline 3 plus Wassermann negative (slow in clearing)
July 28, 1936	Hinton moderately positive Wassermann negative (slow in clearing)
July 31, 1936	Kline 2 plus Wassermann negative
October 20, 1936	Kline 1 plus
December 18, 1936	Kline negative Kahn negative Wassermann negative
August 5, 1937	Kahn 4 plus Wassermann negative (000000) Kolmer
September 11, 1937	Slide test for syphilis by B. S. Kline, M. D. Diagnostic doubtful Exclusion strongly positive
September 24, 1937	Diagnostic doubtful Exclusion strongly positive
January 19, 1938	Kline 2 plus Kahn 3 plus Wassermann negative
July 14, 1938	Kline 1 plus Kahn 2 plus Wassermann negative (000000) Kolmer
December 8, 1938	Kline negative Kahn negative Wassermann negative

COMMENTS

Our clinical results indicate that sobisminol given orally is definitely effective in cases of late syphilis. Sypmtomatic and serologic improvements occurred in all five patients. This is in general agreement with the observations of others.

The daily dosage used by us was much less in four of the patients; that is, one-half to one-third the daily dosage now being used in the Stanford clinics and by others. We used generally three capsules, or 0.6 gram, sobisminol daily as against six to nine capsules, or 1.2 to 1.8 grams daily, used by others. The total number of capsules in these four patients ranged from 300 to 1,200, given in from about eight months to two years. The total amount of sobisminol given ranged from 100 to 219 grams, equal to about 70 to 166 grams of bismuth ion. One patient (J. G.) was given six capsules daily, or 1.2 grams, of sobisminol for twenty-five days, total 30 grams of sobisminol, and then three capsules daily, or 0.6 gram, for sixty days, total 36 grams or a grand total of 60 grams in about three months. These are large doses of bismuth, but the absorption is comparatively small, though adequate for antisyphilitic action.

Considering the large dosage, the tolerance was remarkably good. Two of the patients, Mr. A. W. and Mr. J. G., showed some evidence of intolerance, but were able to adjust their dosages easily, in the one case (A. W.) by "resting" a few days, in the other (J. G.) by taking the capsules before breakfast. All five patients gratefully received the capsules as a substitute for the injections, particularly Mr. A. W. and Mr. W. F., both of whom usually had severe reactions following the injection of neoarsphenamin; the former stating he felt that the capsules were the only medication that helped him, and he always stressed the ease of administration, availability at all times, freedom from serious reaction. Mr. W. F. frequently expressed his gratitude for "such a wonderful medicine that can be taken by mouth."

Unfortunately, we could not make excretion tests under our conditions, and when our treatments were begun, the short clinical method for bismuth in urine, developed by Doctor Hanzlik and assistants,[3] had not been introduced. This test, however, would be desirable control on the oral treatment.

CONCLUSIONS

The oral treatment of syphilis in all its manifestations by sobisminol marks a great advance in the treatment of patients with this disease, and is a worthy addition to our armamentarium. It enhances the success of treatment by the ease of administration over long periods of time, its freedom from serious reactions, its saving of time, and its low cost, making treatment possible in many cases in contrast to comparatively expensive forms in vogue.

Symptoms of intolerance are few and, when occurring, are easily controlled by discontinuing the drug for a few days. As a corollary, sobisminol can be ingested over long periods of time without intolerance, and patients can receive the proper and maximum antiluetic therapy even in secluded places or while away from home.

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URINARY TRACT INFECTIONS

FROM A GENERAL PRACTICE STANDPOINT

By H. C. Bumpus, Jr., M.D.
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PART II*

Discussion *by Charles Pierre Mathé, M.D., San Francisco; Harry W. Martin, M.D., Los Angeles; Frank Hinman, M.D., San Francisco.*

By far the commonest of urinary infections are those of the ascending type, one of the more frequent being associated with the passage of catheters into the bladder. The passage of a urethral catheter on a postoperative patient, followed in twelve or twenty-four hours by a chill and pyuria, is frequently interpreted as indicative of faulty technique in its sterilization, or undue trauma by the nurse or house officer officiating. It is now generally accepted by urologists, however, that the primary cause of such ascending infection has occurred prior to the catheterization. The trauma that has resulted from allowing the bladder to become overdistended being the true etiologic factor, whoever is responsible for the delay in ordering catheterization should accept the blame for the subsequent ascending infection—with its elevated temperature, chills, and fever—rather than the one who actually performed the catheterization. There seems little question that the custom of waiting for surgical patients to void after their bladders have filled is responsible for a far greater number of acute renal infections than the poor technique of nurse or house officer who did the catheterization. Nothing so sets the stage for immediate urinary infection as the overdistention of any part of the urinary tract. The stretching of the mucosa causes a serious hemorrhagic exudate which, in the presence of urine, seems to be the finest of culture media.

ASCENDING RENAL INFECTION

All urologists can attest to the distressing febrile reactions following the first drainage of an uninfected and frequently unsuspected hydronephrosis. Ascending renal infection stands, today, as the most common cause of death associated with the drainage of the overdistended bladder in prostatic obstruction. In this group should undoubtedly be included those disturbances following cystoscopic examination described by the comforting title, postcystoscopic reactions or, in the jargon of the specialist, cystoreactions.

Such an attack of acute ascending infection is usually characterized by frequency, dysuria, fever and, if particularly severe, chills, and was treated, until the decade previously referred to, more or less successfully by the administration of methenamin. Its effect was known to depend upon the liberation of formaldehyd, which could only occur in an acid media, and so acid sodium phosphate was also prescribed to insure acidity of the urine. This method of treatment met with failure in all cases in which the urine remained alkaline, either because of the simultaneous ingestion of alkalizing drugs, or more frequently, due to the presence of a mixed infection in which were included urea-splitting organisms constantly liberating ammonia. In other cases the liberation of the formaldehyd resulted in so much irritation to the urinary mucosa that the symptoms were aggravated rather than improved. When such unfortunate results developed, it was customary to reverse the process by the administration of alkalizing drugs. If the urine was already alkaline, this, of course, brought no relief.

The effect of acid and alkaline values on the power of growth of organisms in the urine is not a new discovery. Kitasabo in 1888 showed media of different acid values will kill, inhibit or allow typhoid or cholera organisms to grow. In 1917 Quinby suggested the investigation of the effect of acids in inhibiting the growth of bacteria in the human being, and Shohl and Janeway later proved that B. coli are inhibited in urine at p^H of 4.6 to 5.0 on the acid side, and 9.2 to 9.6 on the alkaline side. The p^H values for the acid side can easily be obtained by the administration of drugs; but it is not possible in the human being to obtain alkaline values sufficiently high to inhibit the growth of organisms, and not until the degree of acidity or alkalinity in urine could be accurately and easily determinable by calorimeter methods, was rational therapy possible.

ACIDITY AND ALKALINITY: p^H SCALE

Acidity and alkalinity have long been recognized as important factors in practically all branches of research and industrial work. Although it has proved its value and been widely adopted in so many different lines of work, many still hesitate to use p^H methods because they feel that its application requires the services of trained experts. Such misapprehension should not exist, since it it almost as easy to make p^H determinations as it is to make measurements of the rise and fall of the temperature. All are familiar with the Fahrenheit thermometer. On its scale, 32 degrees represents the freezing point. For the sake of illustration, let us assume that values above or below 32 degrees represent degrees of heat and coldness, respectively. Thus, any value higher than 32 degrees denotes an increase in heat, the degree of heat increasing as the numbers increase. On the other hand, any value below 32 degrees denotes an increase in coldness, the decrease in coldness increasing as the numbers decrease.

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* For Part I, see California and Western Medicine, April, 1939, on page 254.

In a similar manner the degree of acidity or alkalinity of a solution is expressed by the p^H scale. Instead of being called degrees, as in the case of the thermometer, the units on this scale are called p^H values. It is apparent that it is not necessary for a person to know the derivation of the term "degree Fahrenheit" in order to determine the temperature of a solution with a thermometer, nor is it essential that one should know the derivation of the term "p^H" in order to measure the acidity or alkalinity of a solution.

On the p^H scale the value of p^H 7.0 represents neutrality. The solution is neither acid nor alkaline. Values higher than 7 denote alkalinity, the degree of alkalinity increasing as the numbers increase. Any value lower than p^H 7 denotes acidity, the degree of acidity increasing as the numbers decrease. This increase or decrease is measured in multiples of 10. Thus, a solution with a p^H of 5 is ten times as acid as one with p^H of 6.0, or a p^H of 4.0 indicates an acidity a hundred times as great as a p^H of 6.0.

The principle of making p^H measurements is based on the fact that various indicators change color when they are acted upon by solutions of different acidities or alkalinities. Until recently it was impossible, except in careful laboratory experiments, to tell the degree of acidity or alkalinity one was dealing with, as the determination of the reaction of urine was ascertained usually by litmus. Now, however, the exact percentage of acidity or alkalinity can be determined by simply dropping a piece of Squibb's nitrazine paper in the urine and comparing it with a color chart. Such accuracy was not possible with litmus paper, for its color range runs from p^H 4.6 to 8.4, which amounts to 3.8 p^H units, and experiment has shown that p^H values of 6.6, 6.7, 7.4, and 7.9 will appear neutral to litmus, while values of 6.8, 6.9, and 7 are recorded as alkaline.

Other indicators, such as chlorphenol red and bromthymol blue, change within a range of 1.6 p^H units and so are more accurate. For the practitioner no indicator is as satisfactory as Squibb's nitrazine papers, which are accurate to one-half unit readings.

ALKALINITY

Although it was shown experimentally that bacterial growth could not be inhibited by any degree of alkalinity obtainable in the human urine, the belief in its clinical virtues persists, based on the following: That the acidity of the urine rather than the products of bacterial growth are responsible for the irritated mucosa with its associated burning, frequency, and tenesmus. In fact, the idea that increased acidity will produce untoward symptoms is so firmly fixed in the human mind that we find the unscrupulous, by a campaign of fear, proclaiming this accepted fact in their national advertising in order to dispose of still greater and greater quantities of alkalinizing drugs. Indeed, today soda fountains are taking on the character of virtual prophylactic stations, where the purchase by the hypochondriac of that universal panacea, Alka-Seltzer, is supposed to prevent the worst. If to this group of distracted citizens one adds the large number of food faddists who, by similar urges, are pursuaded to ingest ever-increasing amounts of pineapple, orange and tomato juice, in order that they, too, may dwell in safety on the alkaline side, it sometimes seems surprising that a normally acid urine is now ever encountered!

The sad part of this erroneously held belief is that there is no evidence to show that an acid urine is irritating, or that an alkaline urine is soothing. The pertinent point is that irritation, frequency and other symptoms associated with urinary infection are the result of the infecting organisms and their by-products, not the result of the reaction of the urine.

METHENAMIN

In our attempt to rid our patient of these various organisms, let us first consider the efficiency of our oldest urinary germicide—methenamin. It is cheap, it has been used for years, and is known to be free of dangers; I have never heard of a death resulting from its administration. To be effective, the urine must be acid in order to liberate formaldehyd, and it is evident that this must be present in the urine in sufficient strength and of long enough duration to be germicidal. If the concentration of methenamin in the urine is .5 per cent and its p^H is 6, bacteria will survive for twenty-four hours; but if the p^H is lowered to 5, it will become sterile in six hours. So it is obvious that it is as important to increase the acidity of the urine as to increase the dosage of the drug to obtain the maximum of germicidal effect. In fact, so many patients are sensitive to formaldehyd that the administration of too large doses of methenamin may lead to a bladder irritability quite as annoying as that caused by the infection itself, and hematuria has not infrequently been produced by the drug alone.

Except for this drawback, methenamin is an ideal urinary antiseptic, inexpensive and efficient. In cases where there tends to be any retention of urine from atony of the bladder musculature, the administration of methenamin may cause sufficient vesical irritation to result in better emptying.

KETOGENIC DIET AND URINE

In 1931 Helmholz noticed that the urine of his epileptic patients who were on a ketogenic diet did not become foul after standing. He reasoned that this urine must contain some bacteriostatic or bactericidal property not present in normal urine. He, naturally, investigated the possibility that its diacetic content was responsible, but as many colonies grow in urine with .5 per cent diacetic as that without, while in ketonurine growth it was much diminished.

At almost the same time that Helmholz was investigating the cause of the bactericidal effects of ketonurine, Anson Clark was searching for some drug or diet that would inhibit the growth of colon organisms. Being informed by Barborka of the extreme degree of acidity produced by the ketogenic diet in children with epilepsy, he at once applied the diet to a large series of adults having urinary infections with surprising clinical results.

Helmholz, having demonstrated that the germicidal properties of this urine were due neither to its acidity nor its diacetic acid content, it was not long before A. T. Fuller of England discovered that the germicidal factor was Levor rotary betaoxybutyric acid. He published his findings in 1933, and it was soon conclusively shown that this acid in concentrations of 0.5 per cent or below was not only bacteriostatic, but definitely bactericidal. But the efficiency of its germicidal effect remained in direct proportion to the p^H of the urine.

Since betaoxybutyric acid is difficult to manufacture, and is also unstable when taken by mouth except for individuals already in ketosis, M. L. Rosenheim searched through the organic acids for one that would be excreted unchanged in the urine. With such an acid he hoped to duplicate the effect of betaoxybutyric. Schotten in 1883, and Knoop in 1905, had showed mandelic acid to be excreted unaltered in the urine. Being used extensively in photography, it was readily available, and Helmholz injected 700 centimeters of a one per cent solution into a dog over a seven-hour period, during which time the concentration of mandelic acid in the urine varied from 1.5 to .5 per cent. The blood urea and urea clearance tests both showed a temporary insult to the kidney as a result of this injection, with complete recovery some three days later.

When given to a patient in doses of three grams of a 10 per cent solution four times a day, the concentration of the drug in the urine rises rapidly to over one per cent; and at a p^H of five a concentration of .25 per cent proves bactericidal for most organisms. As in the case of betaoxybutyric acid, the lower the p^H of the urine the lower is the concentration of mandelic acid necessary to secure bactericidal action. In a series of experiments the bactericidal action of normal urine, to which one per cent of mandelic acid had been added, was found to correspond closely to that of urine to which the same concentration of acid was present on excretion.

Experience has demonstrated that mandelic acid is most satisfactorily administered in the form of its sodium salt neutralized by sodium bicarbonate, and dispensed as a liquid flavored with lemon syrup. A gram of ammonium chlorid should be dispensed with each dose to insure the most effective germicidal p^H level.

In the presence of urea-splitting organisms, such as the proteus ammonia and pseudomonas, the lowering of the p^H may prove difficult or sometimes even impossible to accomplish. In such cases ammonium nitrate, dilute hydrochloric or even nitrohydrochloric, should be tried in association with an acid-ash diet. Such patients should be impressed with the contraindication to the ingestion of citrus fruits, milk of magnesia, or the consumption of large quantities of spinach, celery and other foods of high alkaline-ash content.

If renal function is poor, there is the possibility of producing an acidosis, and it may be impossible with such impairment to obtain sufficient concentration of mandelic acid in the urine to be effective. Under such circumstances the most recent of our urinary antiseptics should be employed.

SULFANILAMIDE

The history of sulfanilamide demonstrates how tedious are our advances in therapy, and illustrates how indebted is the medical profession to the labors of those in other fields of science. Physicians are inclined to forget that neither Pasteur, Roentgen nor Currie held M. D. degrees, and few urologists feel any debt of gratitude or, in fact, remember that Arthur Binz, a German chemist, made intravenous urology possible by his synthetizing uroselectan. So with sulfanilamid the profession is again in deep debt to the chemists of the dye industry that developed this drug.

As soon as the bactericidal properties of sulfanilamid were demonstrated, the determination of dosage and discovery of its toxic effects rapidly followed, and quite as rapidly confusion in its nomenclature developed as different chemical houses applied proprietary names, such as prontylin, prontosil, allum, streptocide, et cetera; so that the Council on Pharmacy and Chemistry of the American Medical Association has adopted the term "sulfanilamid" as a nonproprietary name, and has declared that it is unfortunate that the term "prontosil" is used in this country for a compound not identical with the product that has been used in Europe.

Employed first as a specific agent against streptococcal infections, it has proved equally effective in the urinary tract against the Escherichian coli, while paradoxically it has no effect against streptococcus fecalis. It was soon discovered that larger doses of the drug are better tolerated by the patient in bed, and that much smaller doses must be used in the ambulatory cases. Apparently, a concentration of ten milligram per cent in the blood serum is sufficiently large to insure a germicidal effect in the urine, and this can be obtained by administering 40 to 60 grains a day in ambulatory cases. Reactions vary and must be warned against; happily, if the drug is discontinued at once they subside rather rapidly. The most annoying, although not most serious, are the skin reactions most likely to occur in warm weather, and characterized by extensive erythema and moderate vasiculation. When large doses are given, the blood counts require careful checking, as the destruction of red blood cells has been known to be as high as a million in twenty-four hours.

If the urine is not rendered sterile in a two weeks' period, one may be certain that some abnormal anatomical condition is preventing proper drainage, or that one of the organisms—such as streptococcus fecalis or areabacteric areagenis—is present, and that the battle is going to be hard and long-fought.

It apparently has little effect on streptococcus fecalis, which is the specific organism of impetigo and frequently seems as difficult to eradicate from the urinary tract as from the skin. This organism probably never occurs as a natural invader of the urinary tract, but is carried in on instruments or catheters improperly sterilized. In stained smears it is characterized by the organisms occurring as oval cocci joined together by a refractive streak down the center. When a urinary infection has not responded to this type of therapy, the presence of this organism should be suspected. The administration of the drug by mouth appears to give better results than its administration by needle, and the new form of the drug dispensed under the name of "Neoprontosil," while unquestionably less toxic, seems also less efficacious.

Another advantage of this drug over other urinary germicides is its effectiveness in an alkaline media. So many urinary infections are mixed in character, and not infrequently one of the organisms will be capable of splitting urea into ammonia, so that the possibility of receiving any therapeutic effect from either mandelic acid or methenamin is nil. The pseudomonas and proteus group of organisms are the chief offenders in this respect, although there are some of the cocci that seem but slightly less efficient in the production of ammoniacal urine.

One of the most frequent causes of failure in the treatment of urinary-tract infections in the male is the reinfection of the urine from chronic foci in the prostate. Sulfanilamid is found in the prostatic secretion and would appear, therefore, to be particularly indicated in these cases. Were it not for its distressing side reactions, this drug would indeed seem the ideal urinary antiseptic, but its untoward reactions seem the thorn of this particular rose.

Coccus infections of hematogenous origin, as described earlier in this paper, seem to be little affected by either mandelic or prontylin therapy, while those of the ascending type usually respond to one or the other. Fortunately, the hematogenous type of infection is, in the majority of cases a self-limited affair, from which the patient recovers; but when it assumes a chronic form, treatment by neoarsphenamin has proved the most successful drug for its eradication. Its mode of action is still in dispute, but Pace believes sufficient arsenic is eliminated in the urine to produce a bactericidal effect. This seems somewhat doubtful, however, as such infections, when limited to the bladder, do not respond as well as do those in which the kidneys are also involved. The most efficient and best tolerated dosage scheme is to give two-tenths grams, followed in five or six days by three-tenths grams. If no improvement is noted after these two injections, it is rare for a third dose to produce good results. The elimination of foci in the cervix, prostate, teeth, and tonsils in this type of infection is most important, and until taken care of recurrences seem certain.

IN CONCLUSION

In conclusion, it seems well to emphasize that in the treatment of urinary-tract infections we now have available four efficient drugs, namely, methenamin, mandelic acid, sulfanilamid, and neoarsphenamin. If cases of such infection do not respond to their proper therapeutic administration, the probabilities are great that there are associated pathological conditions in the form of stone, obstruction, stasis or neoplastic disease, which demand thorough investigation by your urological colleague.

112 North Madison Avenue.

DISCUSSION

Charles Pierre Mathé, M.D. (450 Sutter Street, San Francisco).—Doctor Bumpus' timely paper, dealing with the rapidly changing treatment of infection of the genito-urinary tract, will aid in clarifying this obscure subject in the minds of general practitioners. Unfortunately, in our enthusiasm to employ new medicaments, represented as the last word in urinary antisepsis, one is liable to overlook certain fundamental principles of treatment that have stood the test of time and that are so necessary for eradication of infection of the genito-urinary tract. The essayist does well to emphasize the fact that the infecting organism should be identified before it is attacked by a bacteriocide. Good, well-stained smears of urinary sediments are not so difficult to make if one will only take the necessary time and trouble, and then one can always intelligently supplement his studies by culture and animal inoculation. In patients in whom infection persists in spite of the administration of antiseptics that the physician has chosen to administer, further urologic investigation should be carried out. In these patients, stasis is the most common cause of persistent infection. We have seen a number of cases presenting resistent chronic infection in the kidney which cleared up permanently after relieving obstruction, viz., dilatation of a ureteral stricture, corrective plastic repair of hydronephrosis, and suspension of an obstructed, ptosed kidney. Other causes for persistent urinary infection are stone, vesical neck obstructions, foreign bodies, neoplasms, etc. It is obvious that, although infection can be ameliorated in these patients by the use of urinary antiseptics, definite relief cannot be obtained without eradication of the predisposing cause.

Out of the large number of available antiseptics, Doctor Bumpus has chosen four that he feels are most efficacious in combating the different types of urinary infection. These are: methenamin, mandelic acid, sulfanilamid, and neoarsphenamin. To this list I would add methylene blue, whose germicidal effect against cocci, particularly the staphylococcus, has been definitely proved. It is less powerful than sulfanilamid, but is indicated when this drug is poorly tolerated. Methylene blue may also be used to supplement sulfanilamid, in which case it aids in the elimination of that drug, counteracts toxicity, decreases the severity of methemoglobinemia occurring in sensitive patients as well as prolonging bactericidal action. I do not feel that pyridium, caprokol, salol and other antiseptics should be condemned. They have their place, affording relief to certain patients who fail to respond to the four drugs enumerated above; and they are also efficacious in others in whom they are not tolerated.

I am heartily in accord with the opinion that methenamin is an efficient urinary antiseptic, provided that the urine has been properly acidified. We have found its intravenous use, injecting two grams of this drug daily, most efficacious for the treatment of urinary fever, the well-known syndrome of chills and fever that sometimes follows instrumentation. We feel that in many of these cases fever is due to invasion of the blood stream by infecting organisms. Strange as it may seem, we have been able to prevent the development of this type of bacteremia by the previous empirical administration of quinin.

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Harry W. Martin, M.D. (6253 Hollywood Boulevard, Los Angeles).—Doctor Bumpus has given us a very timely paper and one that should be studied by every general practitioner, because urinary antiseptics at this time are a matter of great discussion between physicians and surgeons, and also the laity as well.

It must be borne in mind that, with any infection in the urinary tract, drainage is the most important factor in its treatment, and no urinary antiseptic can be efficient if obstruction to drainage is present.

Another notable point that Doctor Bumpus has brought out is the significance of the Gram stain, which is sufficient for the diagnosis of urinary sediment and more accurate than cultures. Many physicians are of the opinion that in in order to diagnose the majority of urinary-tract infections it is necessary, as Doctor Bumpus points out, to have cultures made. The Gram stain is the most efficient aid we have and everyone can avail themselves of it, and only in certain cases is it necessary for extra laboratory work.

Another point of Doctor Bumpus' worth noting is the necessity of catheterization following operative procedure. Years ago it was taught that catheterization should be resorted to only after every other procedure to empty the bladder had failed, with the result that more damage was done by the distended bladder and its back-pressure changes on the kidneys than could ever be done by catheterizing.

Methenamin is a valuable drug if administered properly when the urine is carefully watched. Fairly large doses should be given if good results are to be obtained, but care must be taken not to cause hematuria.

Sulfanilamide is very likely the most widely discussed drug on the market today, and practically every layman has some slight knowledge regarding it. Like every new discovery, however, care must be taken to see that it is used properly. I recently saw an ambulatory patient who had been taking 80 grains a day for two months, with no change in the urine but a marked change in the blood.

I am firmly of the opinion that if the urine does not show any changes the drugs should be discontinued after two weeks. I also believe that better results are obtained when large doses are given, but that the patient should remain in bed while taking the larger dose.

❊

Frank Hinman, M. D. (384 Post Street, San Francisco).—Between the lines of this report by a specialist, upon the use of urinary antiseptics in general practice, it seems to me that I can read doubt and uncertainty. In his opinion, only four of the myriads of drugs advertised and advocated are at all reliable, and he shows that the potency of each one of these is largely contingent. My own incredulity as to the efficacy of casual medication in the treatment of infections of the urinary tract, as well as my firm conviction that therapy should never replace diagnosis in these conditions, and that when so used it only hinders diagnosis, lets me imagine the more easily, perhaps, this meaning in Doctor Bumpus' paper. His pessimism is fully shared. Most urologists seldom use other drugs than hexamethylenamin, one form or another of mandelic acid—of which a calcium salt has seemed to some less disturbing to most digestive tracts than the sodium—sulfanilamide and arsphenamin. It is important, of course, to know the limitations of use and the prerequisites for greatest efficiency, so ably outlined by Bumpus, of each of these internal urinary antiseptics. Each drug has its own particular field of usefulness, and each, as a rule, acts best only under certain particular circumstances; how useless, for example, are the first two, without proper urinary acidity! Ahead of knowing these contingencies, however, I should place knowledge of the urinary infections themselves. In my opinion, greater attainments are to know well all of the clinical possibilities in both the upper (renal) and lower (urogenital) tracts when pus and organisms occur in the urine; to know when to suspect urinary sepsis as the cause of fever and prostration even in the presence of a negative urine; and, above all, with the clinical induction of the full significance of his history as a guide, to know how to examine the patient for the purpose of diagnosis. The services of a specialist are not required for preliminary studies of this kind, and the routine use of internal urinary antiseptics without such studies is malpractice. The mind of an experienced clinician follows a very simple but logical deduction as facts and findings are brought to it step by step with the history, physical examination and course of clinical events.

The history gives the first lead (the sex, the age, the complaint, and the clinical coincidences). The physical examination gives the next cue (pulse, temperature, palpation of the kidney area, external genitalia, etc.), and then, in the order indicated, laboratory and special investigations (blood counts, urine examinations, particularly the "three glass test," or two if preferred, rectal [and vaginal] examinations with a study of the prostatic secretion, exploration by x-rays, functional tests, occasionally intravenous urograms) will enable the trained clinician to make a very close, if not correct, deduction of the condition, enough at least to tell him whether or not to put his trust wholly in internal urinary antiseptics. *The dangers of procrastination grow greater and greater as urinary antiseptics grow better and better.* Why all this excitement when the ingestion of a few pills clears the urine? The wise doctor, knowing that most urinary infections are secondary, will suspect other trouble even when successful with his pills. He will not be satisfied until all the findings, gradually collected step by step by means of the preceding studies, either demonstrate the suspected pathologic changes or prove that his suspicions were false. In the course of such investigations he may conclude that the services of a specialist are in order (residual urine, cystoscopy? ureteral catheterizations?). Nevertheless, by his knowledge of infections of the urinary tract and his ability to carry out, not as a routine but as indicated, these simple preliminary steps of investigation for which the services of a specialist are not needed, is established the degree of his clinical wisdom. Few conditions exact a graver price for rough handling and mismanagement. None of the preceding studies, however, is instrumental, and all, when rightly used, are perfectly safe. Answers to queries raised by each step of examination are necessary if the clinician expects to meet, in the best scientific manner, the many contingencies of efficiency in the use of internal urinary antiseptics. By the nature of these answers, their fullness and accuracy, is measured his prescience as a clinician. Clinical sagacity in choosing the right road to a correct diagnosis of infections of the urinary tract is the incidental essence of success in their treatment with internal urinary antiseptics.

THE LURE OF MEDICAL HISTORY[†]

MEDICINE IN COLONIAL AMERICA[*]

By David Harris, Ph.D.
Stanford University

I

In a time when medical knowledge has progressed far beyond the scope and imagination of its primitive days, it is natural that we should have forgotten the story of Colonial America's medicine. The worthy preacher has won admiration for his labors, and the legal man's services have rightly received the praise of later generations, but the doctor, crude though he may have been, has been allowed to sink into an unwarranted oblivion. Church and court have not been radically altered; we feel in them strong ties to the past. Medicine, on the other hand, has gone far from the men and practices of the sixteenth and seventeenth centuries. The pioneer ministry of healing, consequently, seems but the most bizarre of unrelated fancies.

[†] A Twenty-Five Years Ago column, made up of excerpts from the official journal of the California Medical Association of twenty-five years ago, is printed in each issue of California and Western Medicine. The column is one of the regular features of the Miscellany department, and its page number will be found on the front cover.

[*] From the Department of History, Stanford University. The author prepared this essay a number of years ago when he was an undergraduate. The friendly interest of an esteemed colleague in the Stanford Medical School has induced him to overcome his hesitations and offer the study to a wider circle of readers.

Yet to the struggling colonists the physicians seemed as indispensable as today, and their ministrations brought blessing and comfort to many. They served as best they could, and for that service they deserve the charitable memory of a generation which has profited by their pioneering.

BARBER-SURGEONS OF EARLY COLONIAL DAYS

In the records of the immigrations to America and of the early settlements there are to be found but few references to officially appointed physicians or surgeons. However, with the ships' crews of the day there sailed, almost without exception, someone who had the official title of surgeon, even though his qualifications were scant. It is not surprising, then, that among the pioneers there should be found men—barber-surgeons at first—who were serving bodily needs. The honor of being the first physician in the colonies is ascribed to Thomas Wooten, surgeon-general of the London Company, who arrived in Virginia in 1606. The next year "Doctor" Walter Russel was in the country, and accompanied Captain John Smith on some of his explorations. These men, along with Anthony Bagnall, must have been, in modern language, transients; for in 1609 the picturesque Captain went to England for treatment for an injury received by the explosion of gunpowder, "for there was neither chirurgeon nor chirurgery at the fort." A year or two later Dr. Lawrence Bohun, former student in Holland, came to Virginia as surgeon-general. Next in time was Dr. John Potts, M.A., who came in 1624; was temporary governor in 1628; and in 1630 was reputed to be the only physician in the colony. This gentleman seems to have been a reckless liver, embroiled in all of the factional intrigues of his time. On one occasion his medical skill alone saved him from being hanged for theft. Seemingly the governor did not have the courage to put to death the colony's only medical man in time of epidemic.

EARLIEST PRACTITIONER IN NEW ENGLAND

The earliest practitioner in New England, and perhaps the first permanent "physician," was Samuel Fuller, who came in the *Mayflower*. He had no medical degree and probably did his ministry of healing and blood-letting in connection with his duties as deacon at Plymouth. In 1629 the Massachusetts Bay Company entered into an agreement with Lambert Wilson, chirurgeon, that he should serve the settlers and neighboring Indians for three years, and give medical instruction to one or two of the young men of the colony. Most conspicuous, however, of the early New Englanders was John Winthrop, Jr., who came to the colony as a doctor in 1630 after graduating from Trinity College, Dublin, and traveling in Holland, France and even Turkey. For years, he was the governor of Connecticut and a writer on a variety of scientific subjects.

In 1626 New York, then Dutch New Amsterdam, received from Holland two *zieckentroosters* who were educated primarily for spiritual ministration, but also had a training in simple healing. Another Dutchman, of perhaps more questionable attainments, came in 1631 as a medical practitioner. Still another immigrant, a Huguenot, came from Leyden in 1637, and he was perhaps New Amsterdam's first regular physician.

One of the founders of Rhode Island was Dr. John Clark, a London physician, who had been banished from Boston along with Roger Williams. In 1633 the General Court gave what is thought to be the first license to practice: Captain John Cranston was licensed "to administer physicke and practise chirurgerie, and is by this Court styled doctor of physick and chirurgery by the Authority of this the General Assembly of this Colony."

Jan Peterson was "barber" to one of the colonies of the Swedes and Dutch on the Delaware at a salary of ten guilders per month in 1638. John Goodson, "Chirurgeon to the Society of Free Traders," is mentioned as the first practicing physician in Pennsylvania. He arrived shortly after William Penn.

Another interesting case where medical skill saved a man's life is that of Jacob Lumbroze, "the Jew Doctor" from Lisbon. In 1656 the Maryland courts condemned him to death under the "Toleration Act of 1649" because of his refusal to accept Christian orthodoxy; but he was pardoned "because of professional knowledge."

ONE HUNDRED AND THIRTY-FOUR PHYSICIANS IN NEW ENGLAND PRIOR TO 1692

But the list must not be continued. The physicians increased as the years went by and kept up their inconspicuous service, thereby being condemned to personal oblivion while collectively perpetuating themselves to the thoughtful reader. In the three generations prior to 1692, one hundred thirty-four men in New England are listed as physicians in name at least. At the close of the Revolution there were from three thousand to thirty-five hundred doctors practicing, of whom not more than four hundred had received medical degrees. Almost twelve hundred men served in the Surgical Service of the Revolutionary Army, and many doctors distinguished themselves in nonmedical contributions. It is interesting to note, in passing, that it was a physician, Dr. Joseph Warren (1741-1775), who found that the British were to attempt to capture the stores at Concord and dispatched Paul Revere. Dr. Ephraim Brevard, a Princeton graduate, drafted the Mecklenburg Resolution in 1755. Among the signers of the Declaration of Independence were several men sometimes styled physicians, but Benjamin Rush (1745-1813) of Pennsylvania was the only genuine doctor of medicine.

Since there were no legal limitations on medical practice, the increase in the number of doctors may be accounted for in several ways. Under the circumstances it was inevitable that many charlatans should set themselves up as healers. Others, like the early Virginia "practitioners," drifted in from the outside world with their varying degrees of knowledge and skill. For example, Gustavus Brown, nineteen years of age, arrived in Maryland in 1708 as surgeon or surgeon's mate to his ship. During the course of a visit to the shore a storm arose, making it necessary for the ship to weigh anchor and quit the port, and Brown was left to build up a medical practice and accumulate a fortune.

PERIOD OF APPRENTICESHIP

In the earlier Colonial period it was the general custom for young men desiring a medical training to take their degrees at Edinburgh, London, or on the Continent. However, there were many aspirants in America too poor to go to Europe, and they indentured themselves for their instruction to practitioners in this country. Many of the successful men gathered around them small groups of students who assisted in the regular practice and listened to occasional talks and lectures, for which they sometimes paid a set fee. This situation was apparently not universally satisfactory. Eliot, the Indian missionary, wrote in 1647: "Our young Students in Physick may be trained up better than yet they bee, who have onely theoreticall knowledge, and are forced to fall to practise before ever they saw an Anatomy [dissection] made, or duley trained up in making experiments, for we never had but one Anatomy in the Countrey, which Mr. Giles Firmin (now in England) did make and read upon very well, but no more of that now."

In the same year the Massachusetts General Court Records printed this suggestive statement: "We conceive it very necessary yt such as studies physick, or chirurgery may have liberty to reade anotomy & to anotomize once in foure yeares some malefactor in case there be such as the Courte shall alow of."

FIRST DISSECTION IN THE COLONIES

Not for over one hundred years do we have records to show progress in this line. In the year 1750 Dr. Thomas Cadwalader, who had been a student in London, gave a series of practical demonstrations of anatomy to his colleagues in Philadelphia. In the same year a criminal in New York City was executed for murder and his body was dissected by Dr. John Bard and Dr. Peter Middleton for the instruction of a group of students in medicine. This is considered the first attempt in the colonies to acquire medical knowledge by dissection.

PENNSYLVANIA HOSPITAL: BENJAMIN FRANKLIN, FOUNDER

Two years later, in 1752, came other adventures in formal medical instruction. The Pennsylvania Hospital, founded in 1750-1751 by Benjamin Franklin and Dr. Thomas Bond, allowed students who were not apprenticed to some doctor the privilege of making the rounds after payment of a "gratuity." In 1773, apprentices were taken for five years, and at the end of his service each man was to receive a certificate and a suit of "cloathes."

ADVERTISEMENT CONCERNING A COURSE IN ANATOMICAL DISSECTION

The following advertisement appeared in the *New York Weekly Postboy,* January 27, 1752: "Whereas Anatomy is allowed on all Hands, to be the Foundation both of Physick and Surgery, and consequently without some knowledge of it, no Person can be duly qualified to practice either: This is therefore to inform the Publick: That a course of Osteology and Myology is intended to be begun, some time in February next, in the City of New Brunswick. (of which Notice will be given in this Paper, as soon as a Proper Number has subscribed towards it.) In which Course, all the human bones will be separately examined, and their Connections and Dependencies on each other demonstrated; and all the Muscles of a Human Body dissected; the Origin, Insertion, and Use of Each, plainly shewn, &c. This course is proposed to be finished in the space of a Month. By

Thomas Wood, Surgeon

N. B. If proper encouragement is given in this Course, he proposes soon after, to go thro' a course of Angiology and Neurology; and conclude with performing all the Operations in Surgery on a Dead Body: the use of which will appear to every person, who considers the Necessity of having (at least) Seen them performed; before he presumes to perform them himself on any living Fellow Creature."

In the same year Dr. William Hunter of New Port, Rhode Island, a relative of two of the greatest medical teachers of England, was delivering lectures on anatomy and comparative anatomy.

LECTURES ON MIDWIFERY PRACTICE

But the man most responsible, perhaps, for the advancement of the study of medicine was Dr. William Shippen, Jr., of Philadelphia, graduate of Princeton and Edinburgh. He returned to his home in 1762 and advertised a course of twenty lectures on midwifery. Up to this time very few men had been engaged in obstetrical work. During the year Doctor Fothergill of London presented the Pennsylvania Hospital library its first volume and seven cases of anatomical charts and casts. To promote further study, Doctor Shippen agreed to display these to interested persons who were willing to give one dollar to the hospital.

ANATOMICAL LECTURES: EXCITING EXPERIENCES

Continuing his work, Doctor Shippen announced a course of anatomical lectures in the *Pennsylvania Gazette.* A portion of the announcement is as follaws: "Philadelphia, November 11th, 1762.

"Mr. Hall

"Please to inform the public that a course of Anatomical Lectures will be opened this winter in Philadelphia, for the advantage of the young gentlemen now engaged in the study of Physic, in this and the neighboring provinces, whose circumstances and connections will not admit of their going abroad for improvement to the anatomical schools in Europe; and also for the entertainment of any gentlemen who may have the curiosity to understand the anatomy of the Human Frame. In these lectures the situation, figure and structure of all the parts of the Human body will be demonstrated, their respective uses explained, and as far as a course of anatomy will permit, their diseases, with the indications and methods of cure briefly treated of."

In February, 1763, the following notice was published: "Dr. Shippen having finished on Osteology—the most dry, though the most necessary part of anatomy—will admit gentlemen who want to gratify their curiosity, to any particular lecture—Tickets five shillings."

His first course was attended by ten students, but in later years attendance at some classes ran as high as two hundred and fifty. There was, on the part of the general public, an aversion to the establishment of a place for human dissection, and on several occasions Doctor Shippen's laboratory was attacked and once his home was mobbed. Doctor Norris says: "In one of these attacks the Doctor, himself, made a narrow escape by passing out through an alley, while his carriage, which stood before the door with its blinds raised, and which was supposed to contain him, received, along with a shower of other missiles, a musket ball through the center of it. More than once he was compelled to desert his own dwelling and conceal himself, in order to avoid the tyrannical exactions of the people. Several times he addressed the citizens through the public papers, assuring them that the reports of his disturbing private burying-grounds were absolutely false, and stating that the subjects he dissected were either of persons who had committed suicide, or such as had been publicly executed; except, he naïvely adds, 'now and then one from the Potter's Field.' "

FIRST MEDICAL DIPLOMA WAS GRANTED BY YALE UNIVERSITY

The first medical diploma given in this country was presented to Daniel Turner by Yale University in 1720. This was an honorary degree conferred on the gentleman after he had made a substantial donation to the school. Latin scholars of the time declared that the M.D. stood for *Multum Donavit*—"He gave much."

EARLIEST MEDICAL SCHOOL OF THE COLONIAL ERA: IN PHILADELPHIA

The earliest formally constituted medical school was the department established in the College of Philadelphia in 1765 under the leadership and instruction of Dr. John Morgan, former student in Europe, and Dr. William Shippen, Jr. Courses were offered in Anatomy and Surgery, "Theory and Practice of Physic," Materia Medica, Pharmacy, Chemistry, Botany, and Natural Philosophy. The fees for single courses under the different professors were not to exceed six pistoles, or twenty dollars, a course. Rigid requirements were laid down for both Bachelor's and Doctor's degrees, and the former degree was conferred on ten candidates on June 21, 1768. The custom of giving a Bachelor of Medicine degree was maintained until 1789. At the Commencement of 1771 four of the first graduates were given the degree of M.D. The College of Philadelphia Medical Department became a part of the University of Pennsylvania in 1791.

KING'S COLLEGE OF NEW YORK FOLLOWS

The Medical School of King's College in the year 1768 became the second and last institution organized before the Revolution. At the end of the year in 1769 two M.D. degrees were conferred, and one of the graduates returned for an M.D. in 1770. This school collapsed during the Revolution and was not revived until 1792 as a part of Columbia University.

Department of History, Stanford University.

(To be continued)

CLINICAL NOTES AND CASE REPORTS

GONORRHEAL VAGINITIS IN CHILDREN*

REPORT OF 548 CASES—1917–1937

By J. C. Geiger, M.D.,
R. W. Burlingame, M.D.
and
Ethel Righetti, M.D.
San Francisco

GONORRHEAL vaginitis in children is not an uncommon disease. Its prompt detection in hospitals and institutions is necessary because of the apparent ease of spread by contact, both direct and indirect. The discharge on the diaper may be the only sign noted. Experience at the San Francisco Hospital of the Department of Public Health indicates the necessity for routine vaginal smears on all patients under fifteen years entering the institution. This procedure is repeated for three successive days and has proved successful in discovering cases heretofore unsuspected and uncontrolled. The usual sources of referred cases are clinics, boarding homes, and private physicians.

CLINICAL MATERIAL FOR THIS STUDY

A series of 548 cases has been observed during the period 1917–1937. The age periods range from two days to fifteen years. The lowest number of cases (7) occurred, respectively, in 1919 and 1920, and the highest number (64) in 1927. It may be of interest that in none of the cases were there such complications as arthritis and pelvic inflammation, so generally noted in gonorrheal infections of the older age groups. Furthermore, when gonorrheal ophthalmia was present, it appeared to have occurred almost concurrently, since both conditions were apparent on entrance in the acute stage. In those cases without gonorrheal ophthalmia, it may be of further interest to note that, despite the fact that no special precautions were taken to prevent this complication, none occurred. Of the total 548 cases, 66 were discharged, usually on the insistence of parents, to private physicians and clinics. Four hundred and ninety-five cases (or approximately 90 per cent), occurred between the ages of two and twelve years; and 220 cases (or approximately 42 per cent), between the ages of six and nine years. Inasmuch as this can be considered a disease without mortality or complications, the efficacy of the treatment used can only be determined by days of hospital stay before the patient is released as cured. The criteria of cure are three consecutive, microscopically negative vaginal smears, the absence of pus cells, and, clinically, no discharge. The smears and examination are to be made at five-day intervals. If previous smears from the urethra showed positive microscopical findings, the same criteria established for the "cures" must be met. It is of decided interest to note that thirty-one patients returned with positive microscopic smears, but with negative clinical findings. These cases were classified as relapses, though the question of reinfection could not be eliminated in many. Eleven additional cases returned twice after being discharged as cured, and one case returned three times. Therefore, in the total number of 482 cases, 42 are to be classified as relapses, or possible reinfections.

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* From the Department of Public Health, City and County of San Francisco.

TREATMENT METHODS DURING DIFFERENT PERIODS

Because of the length of the period under discussion (1917–1937), the methods of treatment have varied with the years. From 1917 to 1921, inclusive, the routine procedure consisted of warm vaginal douches of 1-4000 potassium permanganate, administered night and morning to the patient in a reclining position. This was followed by instillation of 10 per cent argyrol solution with further substitutions of solutions of acriflavin, neo-acriflavin, dichoramin-T in oil, metaphen, and other antiseptics. Such treatment was continued for two weeks, then smears were taken and examined microscopically at the five-day intervals mentioned heretofore. If smears were found positive, the treatment was continued. The average hospital stay for the patients so treated was 97.7 days.

In 1921 the routine treatment was varied to a nightly twenty-minute hot sitz bath at 108 degrees Fahrenheit, and this was followed by a douche with tap water and a vaginal cotton tampon saturated with 4 per cent mercurochrome solution. This tampon was left in place during the night. The following morning, the tampon was removed, and a douche of one gallon of potassium permanganate administered to the patient in a reclining position. This course of treatment was followed for two weeks, and then smears were taken. With few exceptions, this type of treatment was continued through 1934, and the average hospital stay shown to be 91.6 patient days.

In 1932, five cases were selected for treatment by subcutaneous injection with gonorrheal vaccines. In addition, a gonorrheal antigen in jelly was used to replace the usual mercurochrome tampon. Two of these patients were given thirteen injections at four-day intervals. The dose began with 50,000,000 organisms and was gradually increased to 170,000,000. Both patients were released as cured in fifty-four and sixty-four days, respectively. In another patient, six injections of vaccine were administered, while one had ten injections, and another, eighteen. The average hospital stay for this group was 105.7 days. This type of treatment was discontinued.

Table 1.—*Summary Showing Results Under Different Treatment Procedures*

Average time in hospital with douches and local application of antiseptics	97.7 days
Average time in hospital with douches, mercurochrome and sitz baths	91.6 days
Average time in hospital with gonorrheal vaccine (1 m.) and intravaginally	105.7 days
Average time in hospital with 50 to 150 unit doses theelin started late	52 days
Average time in hospital with 50 to 100 doses theelin alone	57.3 days
Average time in hospital with 2,000 unit doses theelin alone	57.2 days
Average time in hospital with 10,000 unit suppositories amniotin alone	44.8 days
Average time in hospital with 10,000 unit suppositories and 2,000 theelin (1 m.)—1 case	89 days
Average time in hospital with 2,000 unit doses of theelin and sulphanilamid—2 cases	49 days
Average time in hospital with 2,000 units theelin (1 m.), 10,000 unit suppositories—2 cases	60 days

In 1933 and 1934, six patients were selected for treatment with theelin. All of these patients had been inmates of the hospital and under routine treatment with chemical douches for 60, 148, 204, 229, 232, and 608 days, respectively, and were classified as a highly resistant type of infection. The results of treatment were interesting. One patient received thirteen intramuscular injections of 1 cubic centimeter (50 rat units per cubic centimeter), of theelin daily; the other patients received twelve, nineteen, twenty-three, thirty-one, and thirty-two injections, respectively. The average hospital stay, after theelin was administered, was fifty-two days.

THEELIN TREATMENT

Beginning in 1935, treatment with theelin was made a routine procedure, and all irrigation and local douche treatments were discontinued. In 1935 and 1936, twenty-nine patients were treated with theelin in doses varying from 50 to 150 units. The average hospital stay of this group was 57.3 days. In addition to these cases, twenty-nine patients were treated during 1936, with an estrogenic substance containing 2,000 rat units per cubic centimeter suspended in corn oil. The average hospital stay was 57.2 days. In 1937, an additional six patients were treated daily with vaginal amniotin suppositories of 10,000 rat unit doses. The average hospital stay for this group was 44.8 days. In 1937, there were three cases treated with amniotin suppositories, theelin, and sulphanilamid. Table 1 summarizes the results of various types of treatment.

IN CONCLUSION

The cases in each of these groups are too few in number to draw definite conclusions. It would appear, however, that estrogenic substances, with or without sulphanilamid, are an improvement over the antiseptic douche.

101 Grove Street.

EXTREME HYPEREXIA AND PROLONGED CONVULSION

ACCOMPANYING HEAT STROKE: COMPLETE RECOVERY

By C. C. Fitzgibbon, M.D.
and
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Merced

Patient, V. S., Mexican, age 43, is a common laborer, and was piling lumber all day on August 2, 1938. The weather was exceptionally warm, temperature rising above 105 degrees in the shade. At 4:30 p. m. he suggested quitting work, sat down to rest, and that is the last he remembered. Coworkers stated that he became delirious and uncontrollable, and it required four men to hold him. He was taken to an emergency station in the lumber camp.

One of us was called by the male nurse at the station, who stated that the patient was having a continual convulsion and his axillary temperature was 110 degrees; breathing was labored and his pulse was feeble and weak. Morphin sulphate, one-fourth grain, was given by hypodermic.

When we arrived the patient was comatose and having a generalized convulsion, which had persisted for one and one-half hours. His skin was dry and hot. Axillary temperature was above the limits of the thermometer, which was 110 degrees. His eyes were opened and fixed, pupils were pinpoint in size, and did not react to light. It was impossible to obtain a radial pulse; breathing was shallow and irregular, and he displayed all the signs of impending death. A tentative diagnosis of heat stroke, with disturbance of the heat-regulating mechanism was made, and symptomatic treatment begun. Ice pack to his head and a cold sponge were given, and 1000 cubic centimeters of normal saline was started intravenously. Then 3¾ grains of sodium amytal were given intravenously, which completely relaxed the convulsion. Two cubic centimeters of coramin, 7½ grains of caffein, and 5 cubic centimeters of metrazol were administered intravenously. Following the normal saline, 1000 cubic centimeters of 5 per cent dextrose in normal saline was given.

One hour after treatment was started, the patient's pulse was of fair quality—96 per minute. The temperature dropped to 103.8, and his blood pressure was 72 systolic; breathing was regular. The patient remained relaxed, but on manipulating his arms a slight generalized convulsion began. Three grains of sodium luminal were given intramuscularly. His condition remained fair, and he was moved by ambulance for twenty-six miles to a hospital. On arrival at the hospital, 1000 cubic centimeters of 10 per cent dextrose in normal saline were given intravenously.

August 3, 1938.

The following morning the patient attempted to get out of bed. He was incontinent, both from bladder and bowels. He would arouse to strong stimuli, but would not respond. He appeared dazed. The temperature was 99.2. A spinal tap was done; spinal fluid was not under increased pressure, and there were no cells found. Red blood cells, 5.14 million; hemoglobin, 80 per cent; white blood cells, 16,800, with 88 per cent polymorphonuclears. Urine showed: specific gravity 1.012, a trace of albumin, an occasional granular cast, and a moderate number of spermatozoa. His deep reflexes were absent. He progressed rapidly, and took nourishment later in the day.

August 4, 1938.

The morning of the second day the patient's temperature was normal. He vomited once, vomitus containing bits of tomato and green peppers, eaten at the noon meal before his illness. The patient was rational, and gave a history of events before that time. Past medical history was entirely negative. No apparent memory loss. Only complaints at this time were: aching in all his muscles, and weakness. Non-protein nitrogen was 26.3 milligrams per 100 cubic centimeters of blood serum. Blood Wassermann and spinal Wassermann were reported negative.

August 5, 1938.

The third day the patient felt nauseated, so nothing was given by mouth, and that day he had three intravenous injections of 1000 cubic centimeters of 5 per cent dextrose in normal saline. His mind was perfectly clear, and a complete neurological examination was normal. His only complaint was a feeling of weakness. Temperature was 99 degrees, pulse 102, and blood pressure 122 systolic and 70 diastolic.

Following this the patient made an uneventful recovery, and was discharged from the hospital on August 10, 1938. At this time there was no evidence of any residual damage to the brain, and complete physical examination was negative. The patient was told to return to his previous job, but to do only light work for a week or so, and at no time become overheated.

October 15, 1938.

The patient was seen at this time for routine check-up. Apparently, he has fully recovered and has no residual damage or ill effects from his illness.

311 Shaffer Building.

ACTINOMYCOSIS WITH SUBSEQUENT EXTENSION AND ABSCESS FORMATION

By Stanley Dougan, M.D.
and
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San Jose

Infection of the human body by actinomyces is relatively common. The original portal of entry is probably the mouth. Naeslum has been able to isolate the aerobic, anaerobic, and combined forms from the normal mouth. Lord and Trevett were able to obtain the organism from dental scum or the contents of carious teeth. The buccal cavity being the portal of entry, vaginal invasion probably comes from the rectum via sanitary pad, toilet tissue, etc. The organism has been found in the uterus, tubes, and ovaries.

REPORT OF CASE

Mrs. D. M., age 49, was first seen by one of us on May 11, 1937. At that time she complained of a painful swelling in her back in the region of the sacrum. This had first appeared in October, 1936, accompanied by practically no pain and little febrile reaction. This original swelling had persisted about two months, and then disappeared almost completely. It reappeared about four months later and gradually extended outward over the right hip. One week before being seen the lesion pointed on the lateral surface of the right ilium. About 500 cubic centimeters of purulent material had drained from the lesion. Past history showed that some swelling and tenderness had occurred in the right inguinal glands a few months prior to the time the swelling appeared in the back.

Physical examination showed a moderately well nourished female. No pathology was found in the head, neck, or chest. All the teeth had been removed. No abdominal tenderness was present nor were any masses palpable. Examination of the area referred to previously showed a sinus opening over the lateral surface of the right iliac crest with a line of induration running backward to the lumbosacral area. Pelvic examination showed the viscera to be normal in size and position. No tenderness was present. Smears from the vagina were positive for actinomyces. This was verified by the clinical laboratory. X-rays of the pelvis revealed an old ankylosed arthritis, involving the third, fourth, and fifth lumbar vertebrae and upper sacrum, apparently nonactive at the present time. Laboratory examination showed the following: white blood cells, 13,000; small lymphocytes, 16 per cent; monocytes, 5 per cent; eosinophils, 2 per cent; neutrophils, 77 per cent, of which 5 per cent were stabs; red blood cells, 4,480,000; hemoglobin, 75 per cent. Blood Wassermann was negative. Urinalysis showed only a trace of albumin.

A working diagnosis was made: "Deep abscess, etiology undetermined."

Treatment.—On June 17, 1937, the patient was taken to surgery and, under a general anesthetic, the abscess was opened and explored. The abscess and accompanying sinus tract extended from a point above the anterior crest of the right ilium back to the lumbar spine. There was no evidence of bone involvement. Many ramifications were present, some of which extended down to, but not through the peritoneum. Cultures were taken and sent to the laboratory. The tract was cleaned and packed with vaselin gauze.

Recovery from the operation was uneventful. The laboratory report on the smears was positive for actinomycotic granules. Postoperative treatment consisted of packing the tract regularly with vaselin gauze and exposing the unhealed areas to ultra-violet rays. Potassium iodid was given during the entire convalescence, the dosage being maintained at maximum tolerance. Because of the depth of the tract and the nature of the causative agent, healing was of necessity slow. On June 20, 1938, the patient was discharged, completely cured.

COMMENT

Apparently, the focus of the infection was the vagina, with extension to the inguinal glands and then the back. The causative organism we believe to be actinomyces.

IN CONCLUSION

We feel that this case is of interest for the following reasons: First, the actinomycotic infection apparently extended from the vagina through the inguinal glands, forming the sinus tract that ultimately resulted in abscess formation. Second, complete healing of these deeply infected areas is unusual—so often we find sinus tracts remaining. Third, we feel that we were definitely able to determine the original location of the causative agent.

Medico-Dental Building.

CHANCROIDAL BUBO CURED BY SULFANILAMIDE

By J. F. Doughty, M.D.
Tracy

Mr. M. H., age 22, noted a "sore" on the glans penis about one week after intercourse. He came under my observation about four days later, at which time there was an ulcerated lesion completely destroying the frenulum, and extending into the superficial tissues of the glans penis. The inguinal glands were slightly enlarged. Darkfield examination for Spirocheta pallida was negative. Under treatment with mild antiseptic washes and dressings, the lesions healed very slowly. Two months later, with the lesions still not completely healed, the patient developed large inguinal buboes on the left side. The swelling was the size of a lemon, and there was redness of the skin around the area for a distance of about three inches. The swelling was hard and moderately tender. The patient's temperature was normal, but he felt sick.

Sulfanilamide was administered orally, 20 grains every four hours for four doses, and 10 grains four times daily, to a total of 250 grains. Within twenty-four hours the patient felt considerably better, and recession of the swelling was quite noticeable. At the end of five days the ulcer was entirely healed, and the glands were no larger than small walnuts. They continued to recede. There has been no recurrence.

In this case an ulcerated chancroid, which healed very slowly and developed buboes after two months, responded after the administration of sulfanilamide.

231 West Eleventh Street.

TRICHINA SPIRALIS: ITS INCIDENCE IN NECROPSY MATERIAL*

By E. M. Butt, M.D.
and
J. L. Lapeyre, M.D.
Los Angeles

Routine examinations of human postmortem material for the presence of Trichina spiralis have yielded interesting information regarding the incidence of trichinosis. Percentages of infestation, ranging from 3.5 to 27.6, have been reported from widely separated localities. When it is realized that one-third to one-half of these patients probably have had clinical symptoms of the disease, a morbidity figure is obtained that is not only startling, but extremely important to the clinician and public health officials. In the papers of Queen,[1] Hall and Collins,[2] Riley and Scheifley,[3] Hinman,[4] McNaught

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* From the Laboratory of the Santa Fe Coast Lines Hospital, and the Department of Pathology, University of Southern California School of Medicine, Los Angeles.

[1] Queen, F. B.: The Prevalence of Human Infection with Trichinella Spiralis, J. Parasitol. 18:128 (Dec.), 1931.

[2] Hall, M. C., and Collins, B. J.: I. The Incidence of Trichinosis as Indicated by Postmortem Examinations of Three Hundred Diaphragms, Pub. Health Rep., Vol. 52, No. 16 (April), 1937. II. Some Correlations and Implications in Connection with the Incidence of Trichinae Found in Three Hundred Diaphragms, Pub. Health Rep., Vol. 52, No. 17 (April), 1937.

[3] Riley, W. A., and Scheifley, C. H., Trichinosis of Man—A Common Infection, J. A. M. A., 102:1217 (April 14), 1934.

[4] Hinman, E. H.: Trichiniasis in Louisiana, New Orleans M. and S. J., 88:445-448 (Jan.), 1936.

Table 1

Age	Total Number of Cases	Positive Cases Number	Positive Cases Per Cent	Per cent Positive 0–50 yrs.	Per cent Positive 51–100 yrs.	State of Trichina Number of Cases Cysts	State of Trichina Number of Cases Live Worms
10–20	8						
21–30	6						
31–40	25	6	24.0	15.8		3	5
41–50	24	4	16.7			3	1
51–60	40	6	15.0			5	2
61–70	35	8	22.8		19.6	7	1
71–80	25	6	24.0			6	1
81–90	7	1	14.2			1	
Total	170	31	18.2			4 Heavy Infestations 27 Light Infestations	

and Anderson,[5] and Magath,[6] are found complete discussions of the methods used, presentation of the statistics and summaries of the literature.

Inasmuch as no reports of the incidence of trichinae infestation in cadavers have appeared from Southern California, we thought it of interest to record our findings.

METHODS AND RESULTS

This study is based upon the examination of human diaphragms by the digestion method. The method used in digesting the muscle is essentially that described in the article by McNaught and Anderson.[5] The diaphragms were stripped free of fat, weighed, and ground in a meat grinder. Fifty grams of the ground muscle were mixed with 500 cubic centimeters of 0.7 per cent hydrochloric acid, and 1.5 per cent granular pepsin. The mixture was then agitated by means of a mechanical stirring device arranged within an incubator (37 degrees centigrade), and allowed to remain over night. The incubation period varied from fourteen to eighteen hours. The following morning the material was passed through brass mesh sieves, No. 40 and No. 60, and allowed to settle in a large glass funnel, to which was attached a rubber tube closed by a pinchcock. The filters were rinsed several times with normal saline solution. After allowing the entire mixture to settle for one-half to two hours, small portions of the sediment were drawn off into a petri dish and examined under a microscope equipped with a 35-millimeter objective. Liberated trichinae and cysts were easily identified. In the event no trichinae were found, larger quantities of the sediment and washings from the apparatus were examined.

Diaphragms containing more than one hundred cysts or larvae were considered to be heavily infested. Not more than five to ten trichinae were found in the average case.

The results of the examination of 170 diaphragms are recorded in Tables 1 and 2. It will be noted that 18.2 per cent were found to be infested with either trichinae, cysts, or with both cysts and worms. Four of the thirty-one positive diaphragms were classified as heavily infested, while of the remaining twenty-seven diaphragms only one to ten trichinae were found in each instance.

Fourteen cases in the age groups from ten to thirty years were negative. In the remainder of the cases separated according to age, little variation in infestation was noted.

Further analysis of the data is presented in Table 2. It will be noted that there is a higher percentage of infestation in females than in the males. This is due to the higher incidence of trichinae in colored and Mexican females than in males of the same races. The differences in the percentage of infestation of white males and females are not significant.

Over 95 per cent of the diaphragms used in this study was obtained from the Los Angeles County Hospital. This fact, in addition to the variations in the degree of infestation in the colored and white groups of the series, may have an implication regarding the percentage of infestation in the population at large. The explanation for the higher percentage of positivity in colored and Mexican females, in comparison with the males of the same races, is not apparent. However, it is apparent that less discrimination is practiced by individuals of the latter groups in the selection and preparation of pork products.

It is interesting to point out that none of the past histories of the positive cases contained information upon which to base a diagnosis of trichinosis.

Table 2

	Total Number in Group	Number Infested	Per Cent Infested
Males:			
White	80	10	12.5
Colored	10	3	30.0
Mexican	23	4	17.3
Total	113	17	15.0
Females:			
White	38	4	10.5
Colored	7	4	57.1
Mexican	12	6	50.0
Total	57	14	24.5
Males and Females:			
White	118	14	11.8
Colored and Mexican	52	17	32.6
Total	170	31	18.2

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[5] McNaught, J. B., and Anderson, E. V.: The Incidence of Trinchinosis in San Francisco, J. A. M. A., 107:1446–1448 (Oct. 31), 1936.

[6] Magath, Thomas B.: Encysted Trichinae, Their Incidence in a Private Practice and the Bearing of This on the Interpretation of Diagnostic Tests, J. A. M. A., 108, No. 23 (June 5), 1937.

In the histories in which blood studies were recorded, the eosinophile counts were within normal limits.

It is quite apparent from the foregoing data that trichinosis is as prevalent in Los Angeles as it is in other cities in which surveys of trichinae infestation in cadavers have been made. This information becomes even more startling when the percentages of infestation are transferred from the dead to the living. The droll implication is that nearly one-half million residents of Los Angeles County eat undercooked, infected pork, and carry worms in their muscles.

SUMMARY

1. Eighteen and two-tenths per cent of diaphragms examined by the digestion method were found infested by Trichina spiralis.
2. The percentage of infestation is much higher in Mexicans and colored people than in the white population.
3. Four of the thirty-one positive diaphragms were found to be heavily infested.
4. A definite clinical history of trichinosis was not found in any of the positive cases.

University Park.

HUNNER'S ULCER AS AN UNSUSPECTED CAUSE OF GASTRO-INTESTINAL SYMPTOMS

By Fred H. Kruse, M.D.
and
Walter W. Herrmann, M.D.
San Francisco

In 1914 Hunner[1] reported, before the Southern Surgical and Gynecological Association, a series of eight cases having a hitherto undescribed lesion of the urinary bladder. These cases all occurred in women, since his practice was so limited. At the time, however, he predicted that the lesion also occurred in men, and since then this has been reported.

This lesion is characterized by intractable bladder pain, frequency and burning on urination, a low bladder capacity, and paucity of changes in the chemical, microscopic, and bacteriologic study of the urine. The cystoscopic examination, unless carefully done with this lesion in mind, is frequently reported as negative, and half the women in Hunner's group had been subjected to extravesical surgery before the lesion was recognized.

The cystoscopic picture consists of very minute ulcerations through the mucosa, 1 to 5 millimeters in diameter. These are surrounded by radiating, dilated capillaries, and a zone of edema 4 to 5 centimeters in diameter. The ulcerated area bleeds readily if the bladder is overdistended, or is touched by instrument or cotton pledget.

The tissue changes consist of a small zone of epithelial destruction, with regeneration around the margins of the ulcer. The underlying submucosa shows extensive fibroblastic proliferation, an increase in the number of capillaries, and infiltration with inflammatory cells over a zone much wider than the ulceration. The inflammatory cells are chiefly polymorphonuclear, but mononuclear cells are present in abundance.

Urinary examination shows little to account for the cystitis, at most a very few red blood cells; although the patient will have noted, in some instances, some blood in the urine. Cultures of the urine have been consistently negative, and search for tubercle bacilli has been fruitless.

The tissue changes present have given the lesion the aptly descriptive name of submucous fibrosis of the bladder.

While the typical symptomatology leaves no doubt as to the site of the disturbance, there are occasional cases, exemplified by the fourth case of Hunner's series and the one here reported, in which the presenting complaints and symptoms are misleading.

REPORT OF CASE

A 58-year-old white housewife was first seen in September, 1937, complaining of abdominal distention with gas, belching, and flatulence. Accompanying the distention there was severe vaginal pain and urinary frequency. Her symptom-complex started with the abdominal discomfort which came immediately after or during meals, and produced the intolerable pain in the vagina. The symptoms had been present for four years, and she was accustomed to being forced to hurry from the table during this period of time in order to relieve herself of accumulated rectal gas and thus ease her pain. If this was not successful she would resort to enemas or sitz baths. The pain occurred so promptly after the ingestion of any food and most liquids that she was undernourished, very nervous, apprehensive, and afraid to eat.

She gave a story of lifelong constipation, with the habit of regular, frequent use of the enema tube because the use of cathartics and their resultant cramping aggravated the intense vaginal pain. There was no rectal pain and no burning on urination. Her sole urological complaint was frequency, which she stated always came and was made worse with the accumulation of gas in the bowel. Her past history and inventory of systems were not relevant.

The positive findings in the physical examination were: a small, undernourished, pale, apprehensive woman. Weight, 94½ pounds; height, 59 inches. The turbinate bones were large and covered by reddened, thick mucous membrane. The tonsils were large and showed moderate infection. The mouth was edentulous, the last teeth having been removed some three months previously because of infections. The heart was small, rate 92 with a slightly impure, first sound and a faint systolic murmur. The blood pressure was 162/100. The peripheral vessels were slightly sclerotic. There were a few, diffuse, sibilant squeaks throughout the lung fields, which were thought to be atalectatic in origin. The abdominal wall was relaxed, with moderate diastasis of the recti muscles. There was much crepitus and gurgling of gas on manipulation of the abdominal contents. The wall was held semi-rigid, and the ascending and descending portions of the colon could be felt as contracted, firm cords. The rectal sphincter was spastic and the pelvic examination revealed nothing of note. The urine showed a faint trace of albumin, five to seven pus cells and two to five red blood cells per high dryfield. Blood count showed a secondary anemia.

Roentgenological examination of the gastro-intestinal tract showed evidence of colon irritability and a questionable filling defect in the rectosigmoid junction, which has since been shown to fill out.

After three weeks' trial on carefully outlined and faithfully executed colon management, she reported back with no relief of symptoms. At that time she was referred for a study of the urinary tract. The cystoscopic investigation revealed a submucous fibrosis in the vault of the bladder, which was then cauterized. When seen three days later there was still some slight urethral irritation, but practically all of the agony she had suffered for four long years had subsided. In three weeks' time her only symptoms centered about the constipation. In three months' time her weight had increased by ten pounds, and this has been maintained at that level since. There have been several recurrences of the bladder symptoms, necessitating repeated fulguration, which is a typical story of Hunner's ulcer. Between fulgurations, however, she has continued to enjoy reasonable comfort and health.

384 Post Street.

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[1] Tr. South. Surg. & Gynec. Assoc., 27:247, 1914.

BEDSIDE MEDICINE FOR BEDSIDE DOCTORS

An Open Forum for brief discussions of the workaday problems of the bedside doctor. Suggestions of subjects for discussions invited.

HERPES ZOSTER

I. ETIOLOGY

Samuel Ayres, Jr., M.D. (2007 Wilshire Boulevard, Los Angeles).—Herpes zoster belongs in the group of virus diseases and, etiologically, is in the same category with variola, varicella, anterior poliomyelitis, encephalitis, herpes simplex, verruca, molluscum contagiosum, etc. A considerable amount of investigation has been done which points to the probability that the virus causing herpes zoster, and that causing varicella, are either identical or very closely related, and differ from the virus causing herpes simplex. R. T. Brain pointed out that the serum of persons convalescent from zoster and varicella contains specific antibodies which can be demonstrated by complement-fixation, using the vesicle fluid as antigen. According to Brain, fluid from zoster vesicles gives equally good fixation with zoster and varicella serum, and the same is true of the fluid from varicella vesicles. This work confirms similar findings of Netter and Urbain. C. R. Amies called attention to the fact that "elementary bodies" (cell degeneration products), morphologically similar to those found in varicella and vaccinia, are constantly present in the fluid from the vesicles of zoster. He demonstrated that pure suspensions of these bodies, prepared by high speed centrifugation of fluid from the vesicles, are specifically agglutinated by zoster convalescent serum. Attempts to demonstrate a relationship of zoster and varicella by means of cross-agglutination tests have met with a fair measure of success. Both Kundratitz and Bruusgaard were able to cause varicella by inoculating children with the vesicle fluid from cases of herpes zoster.

Bokay, in 1888, first called attention to the possibility of a relationship between herpes zoster and varicella, and since then many clinical observations have tended to confirm this idea. As stated by Andrews, "the usual circumstances are that a case of herpes zoster is followed in fourteen to sixteen days by outbreaks of varicella in associated persons who have not, so far as is known, been otherwise exposed to varicella infections."

Wise and Sulzberger conclude that "it, therefore, seems possible that zoster is an eruption of altered type, a relatively immune or allergic type of chickenpox, which occurs in those whose tissues have been specifically changed in their capacity to react through previous acquaintance with the same virus (allergy). This previous acquaintance may have led to preceding clinical disease (in the form of chickenpox, perhaps many years previously) or may have been subclinical, as is the case in many instances of other diseases (diphtheria, poliomyelitis, etc.).

"This hypothesis, which requires confirmation through adequate study and experimentation, would explain why, as a rule, (1) herpes zoster is rare in children; (2) chickenpox is rare in adults; (3) inoculation of the virus of a case of chickenpox produces chickenpox in children and zoster in adults; and (4) the zoster vesicle virus produces chickenpox in children and zoster in adults."

Practically nothing is known regarding the usual mode of transmission of the virus of zoster. The disease must be very feebly contagious, inasmuch as it is quite uncommon for more than one member of a family to be affected, although a number of such occurrences are on record. The virus certainly must in some manner find its way to the posterior or sensory nerve root, as indicated by the following observations: (1) Inflammatory and degenerative changes have been found in the posterior nerve roots or root ganglia; (2) spinal fluid changes with increased pressure have been demonstrated; (3) pain usually precedes the eruption; (4) the eruption is usually centrifugal in its development.

The disease is thus a posterior poliomyelitis, and yet inoculation experiments with vesicle fluid clearly indicate that the virus must travel along the nerve and finally appear in the skin. The claim has also been made that the virus may appear first in the skin and travel along the nerve toward the spine, but this is probably not the usual course of events.

The fact that many cases of zoster have closely followed trauma, such as back injuries, spinal puncture, spinal manipulation, etc., suggests that the clinical picture of herpes zoster may be produced by mechanical means. Zoster has also been reported as being caused by chemical poisons, such as arsenic, streptococci from foci of infection (Rosenow and Oftedal), malaria, septicemia, spinal-cord tumors, tabes, springomyelia, leukemia, etc. The occurrence of zoster in connection with the above-mentioned conditions does not prove, however, that such eruptions are not of virus etiology. Such extraneous factors may have served merely to lower the resistance, thereby allowing a latent virus infection to manifest itself in the same way that exposure to the sun or a bad cold, by lowering the resistance either locally or generally, allows a latent herpes simplex to flare up. The virus etiology of herpes simplex can be easily demonstrated by animal inoculation with vesicle fluid, even when precipitated by physical agents; whereas the virus in the vesicle fluid of zoster is not readily transmissible to animals, although, as mentioned before, it can produce either zoster or varicella on human inoculation. Inoculation experiments with vesicle fluid from cases of zoster apparently of traumatic origin would be interesting.

The virus of herpes zoster generally stimulates the development of an immune state, so that the disease is self-limited and usually does not recur. This is a strong argument for the differentiation of zoster virus from the virus of herpes simplex where no immunity is established. The difference in behavior of the two viruses on animal inoculation is further evidence of the separate nature of the two viruses.

* * *

II. DIAGNOSIS

Stanley O. Chambers, M.D. (826 Roosevelt Building, Los Angeles).—Herpes zoster presents such characteristic features that it is one of the easiest of all cutaneous diseases to recognize. A unilateral eruption, consisting of groups of rather large vesicles upon an erythematous base, following the course of cutaneous nerves and accompanied or preceded by neuritic pains, is characteristic of herpes zoster. If one has the good fortune to always have ready these cardinal features, little or no difficulty should be encountered in diagnosis. Often, the preceding neuritis represents the only diagnostic evidence—and, although a conclusion cannot be drawn, it is generally good judgment to observe for herpes zoster any unilateral pain following the course of a cutaneous nerve. Erythematous patches may soon appear with their characteristic, superimposed vesicles. Preceding neuralgic pains usually announce the skin lesions to follow. Characteristic skin lesions of herpes zoster can develop, however, with little or no pain preceding their appearance. Pain is variable at the onset, and may vary from a negligible degree to the severity of a passing ureteral stone or acute mastoiditis. Surgical errors have been made during this phase of the disease. The cutaneous lesions are comprised of two elementary ones, erythematous patches and vesicles superimposed. Although these two phases are distinct in development, the time interval between is never great. The degree of definition of both phases is variable. The erythematous patches may be very indefinite or extremely prominent. Likewise, the vesicles may be large and numerous or small and few. Never, however, are either of these two phases insufficient to avoid clinical detection. The erythematous patches, with their superimposed, grouped vesicles, follow accurately the distribution of the nerve or nerves affected. The most frequent regions affected are those supplied by the intercostal, lumbar and trifacial nerves, although any portion of the cutaneous surface may be involved. The enlargement of adjacent lymph glands, although not always found, represents a rather consistent and diagnostic feature. These glands share in the inflammatory phase of the disease and are seen at the onset of the cutaneous lesions, slowly subsiding in relation to the involution of the acute phase of these lesions. The neuralgic pain usually preceding the eruption may persist throughout the course of the disease, with more or less severity, and may too frequently persist for months following the complete healing of the cutaneous lesions (postzoster neuritis). Rarely experienced is the development and healing of herpes zoster without pain.

This is, indeed, in contrast to the usual development of herpes simplex without pain, and represents a differential feature. Severe pain is an expected accompaniment and usually represents the outstanding treatment problem. In the course of the disease the vesicles which do not tend to spontaneous rupture dry upon the skin as yellowish-brown crusts and fall off.

Then here again the ready tendency to early rupture of its superficial vesicles is characteristic of herpes simplex. The entire pathologic process may be so slight as to leave no sequelae at the site of the healed lesions.

This is consistently true of herpes simplex, but in herpes zoster the degree of severity may vary: the simple vesicles may become purulent, hemorrhagic, or gangrenous. The duration of the disease and the cutaneous sequelae may likewise vary. Three to six weeks might elapse from onset to healing, and extensive deep scarring result. It is of diagnostic importance to observe that severity, duration and sequelae appear more extreme in older individuals and less so in young ones. Prognosis, therefore, where the disease involves specialized structures, can from this observation be better interpreted. The disease is self-limited, varying in duration from one to five weeks. It is no more common in men than in women. It affects the elderly more commonly than the young. Histopathologic evidence, although presenting characteristics common to herpes zoster, smallpox, and chickenpox, is rarely used in diagnosis.

Differential diagnosis should not be confusing in unilateral herpes zoster. Where the disease expresses itself bilaterally or as a generalization, however (herpes zoster generalizata), differential problems might arise; but, fortunately, this is extremely uncommon.

The sudden onset of unilateral pain, followed by the development of grouped vesicles on an erythematous base along the distribution of cutaneous nerves, should always serve to identify herpes zoster without difficulty.

* * *

III. TREATMENT

Merlin T.-R. Maynard, M.D. (407 Medico-Dental Building, San Jose).—Since a discussion of treatment of this disease is to be found in textbooks of general medicine as well as dermatologies, it is my intention to give a résumé of my own preferences and routine procedures. The case of herpes zoster, after being questioned in relation to possible sensitivity to iodin and considered from the standpoint of age and physical condition particularly as regards hypertension or arteriosclerosis, is, if regarded as a good risk, treated as follows: One or two grams of sodium iodid are given intravenously. One cubic centimeter of surgical pituitrin is mixed with five cubic centimeters of whole blood, and injected intramuscularly. This treatment is repeated daily for three days, and every second day after that if necessary.

The above treatment is chosen to make use of the exudate absorption effect of sodium iodid with the vasoconstrictor effect of pituitrin. The whole blood is used to delay the absorption of the pituitrin and prevent the annoying peristaltic activity which would otherwise be considerable. All three of the above agents have been advised by different authors, and I have used them individually as well as together.

I have seen abortive effects from sodium iodid in early cases. Pain is often not relieved by sodium iodid. It is often dramatically relieved by pituitrin, and less often by autohemotherapy. I believe the combination of the above three treatments to be the most effective routine for the average case.

Recently, vitamin B has been widely used internally, with various reports of success; however, it has also been apparently a causitive factor in one author's experience.

Local treatment is often not necessary, aside from protection and antisepsis. Spraying with ethyl chlorid has been useful in relieving local pain, as has also painting with collodion. Dry heat is helpful. Powders and drying lotions are also recommended. Ointments are not used in the treatment of zoster *per se,* but only to control secondary infection. If the case is seen late, and gangrene and sloughing are present, the indication is one of control of infection. Gentian violet, compresses, and antiseptic ointments, such as 5 per cent ammoniated mercury, are all used according to usual practice in infected wounds. The sloughing skin is trimmed away as it separates.

"After Pain." An unfortunate and regrettable occurrence, particularly in the aged, is the matter of "after pain." This may be neuralgic or of the intense burning sympathetic type. I believe that sodium iodid therapy helps to prevent this complication. If the pain is of the neuralgic type, section of the nerves involved is helpful. If of the sympathetic burning type, section of the sympathetics is accomplished by tying and severing the larger blood vessels leading to the area. Relief is usually partial and not complete. In one case in my experience of the ophthalmic distribution, cocainization of the sphenopalatine ganglion gave temporary relief. Alcohol injection was not done, due to the poor condition of the subject. "After pain" may persist for only a few days, but often continues for months or years. It is commonly of such severity that morphia or dilaudid is needed, and the patient may seek relief in suicide.

Teaching of Night-Driving Technique Is Urged by Journal.—Teaching of night-driving technique as a part of the initial training of motorists is advocated by *The Journal of the American Medical Association* in an editorial, "Motor Accidents at Night," in its April 8 issue.

"Numerous accidents at night on the highways continue to indicate the need of more adequate supervision of traffic," the editorial says. "Whereas the enforcement of traffic laws has heretofore been mainly a day-time activity, many cities are now placing policemen on streets to handle traffic during the dark hours. Most motorists obtain their experience and training under daylight conditions; the problems that arise at night have not been sufficiently impressed on drivers, and traffic engineering has not kept pace with the situation. The fatal motor accident rate at night, on the basis of traffic, is more than three times the accident rate during daylight.

"Motor-vehicle fatalities during the hours of darkness have increased 43 per cent since 1930. The entire increase in traffic deaths in 1937 over those in 1936 resulted from the increase in night accidents. However, the recent emphasis on safe driving at night is producing results. The Committee on Night Accident Hazards of the National Safety Council reports for the first six months of 1938 a reduction of 26 per cent in the motor fatalities occurring during dusk and darkness.

"In its analysis of the problem the committee finds that eyesight, driving experience, and mental attitude are the important factors in the driver himself. He, too, is responsible for the associated problems of intoxication, speed, fatigue, and age. The committee found that 78 per cent of the accidents in which the driver had been drinking occurred between 6 p. m. and 6 a. m. Further studies on intoxication as related to driving accidents are under way. Night driving involves a different technique from day driving because of the difference in visibility and in the reactions of the driver. Motorists should be taught night-driving technique in their initial training. Much can be done to eliminate the hazards which are the result of low visibility at night. Highway officials should insist on the best design and maintenance of highways with adequate signs and warnings designed for good visibility at night. An improved type of lighting the highways is being installed in many places throughout the United States. The most common method of lighting the road is by means of headlights. Unfortunately, the possibilities in head lamps on cars have not been developed as rapidly as those of other parts of the car. Headlights lose as much as half of their original effectiveness in a short time unless they are kept clean and adjusted. The committee recommends that officials consider the importance of securing adequate visibility for night driving and promote safety through the installation of good illumination for the heavily traveled and dangerous main highways and by the installation of flood lights at such hazardous locations as railroad crossings, intersections, and special entrances.

"Recently the Michigan Highway Department studied the use of reflector buttons on rural highways. Units were spaced 100 feet apart and 8 feet from the edge of the pavement on eighty miles of road between Lansing and Detroit. In the first three months of 1938 there was a reduction of 79 per cent in accidents on this stretch of highway, whereas on a control stretch of highway the reduction was only 19 per cent.

"The night pedestrian is susceptible to accidents. Night pedestrian fatalities in Philadelphia increased from 56 per cent of the total number of night fatalities in 1935 to 73 per cent in 1937. In New Jersey, in 1936, 67 per cent of the urban pedestrian fatalities and 83 per cent of the rural pedestrian fatalities happened at night. The committee urges that the pedestrian give the motorist every possible opportunity to see him. If it is necessary to walk at night in rural districts the pedestrian should carry a light when practicable and wear light-colored clothing. Even carrying a white handkerchief is a considerable aid. Because the pedestrian sees the motor's headlights does not mean that the motorist sees him.

"The night limits the speed for safe driving. The National Conference on Street and Highway Safety recently fixed forty-five miles an hour as the *prima facie* speed limit at night in sections where the corresponding day limit is fifty miles an hour. Lower speeds are necessary in many places. Drivers should lower the speed at night in order to keep their safe stopping distance within the range of clear visibility. Safe driving at night is a challenge to the ingenuity of the driver, who must be alert for every indication of objects ahead or changes in the road."

CALIFORNIA MEDICAL ASSOCIATION

This department contains official notices, reports of county society proceedings and other information having to do with the State Association and its component county societies. The copy for the department is submitted by the State Association Secretary, to whom communications for this department should be sent. Rosters of State Association officers and committees and of component county societies and affiliated organizations, are printed in the front advertising section on pages 2, 4 and 6.

CALIFORNIA MEDICAL ASSOCIATION†

WILLIAM W. ROBLEE	President
CHARLES A. DUKES	President-Elect
LOWELL S. GOIN	Speaker
KARL L. SCHAUPP	Council Chairman
GEORGE H. KRESS	Secretary-Treasurer

OFFICIAL BUSINESS

ASSOCIATION ACTIVITIES

1. *American Medical Association, Official Call: Annual Session.*
2. *California Medical Association: Sixty-Eighth Annual Session.*

DEPARTMENT OF PUBLIC RELATIONS

1. *On California's Proposed Compulsory Health Insurance Law (A. B. 2172).*
2. *General Hospitals and the Wagner Bill.*
3. *Orange County Medical Society Circularizes Employers of Labor.*
4. *Compulsory Health Bills.*
5. *Assembly Bill 2172 and Senate Bill 1128.*
6. *Some Objections to Senate Bill 1128 and Assembly Bill 2172.*
7. *California Physicians' Service.*

AMERICAN MEDICAL ASSOCIATION

Official Call: Annual Session

To the Officers, Fellows and Members of the American Medical Association:

The ninetieth annual session of the American Medical Association will be held in St. Louis, Missouri, from Monday, May 15, to Friday, May 19, 1939.

The House of Delegates will convene on Monday, May 15.

The scientific assembly of the Association will open with the general meeting, held on Tuesday, May 16, at 8:30 p. m.

The various sections of the scientific assembly will meet on Wednesday, May 17, at 9 a. m. and 2 p. m. and subsequently according to their respective programs.

IRVIN ABELL, *President.*
H. H. SHOULDERS, *Speaker, House of Delegates.*

Attest:

OLIN WEST, *Secretary.*
Chicago, March 25.

CALIFORNIA MEDICAL ASSOCIATION: SIXTY-EIGHTH ANNUAL SESSION

The May issue of CALIFORNIA AND WESTERN MEDICINE will be in press at the time the California Medical Association will be in session (May 1 to 4).

In this issue of the OFFICIAL JOURNAL it is only possible to list the names of newly elected officers and to present the address of the retiring president, William W. Roblee, M.D. Full reports will appear in the June issue.

C. M. A. DEPARTMENT OF PUBLIC RELATIONS†

ON CALIFORNIA'S PROPOSED COMPULSORY HEALTH INSURANCE LAW (A. B. 2172)

Recently, the secretary of the California Medical Association Department of Public Relations wrote to friends in the East, requesting comments on certain phases of A. B. 2172, now before the California Legislature. Reply follows:

April 5, 1939.

Dear Doctor Kress:

To comply with your request for information concerning the probable outcome of the proposed amendment to the Unemployment Reserves Act would require considerably more time than the few days allowed. Enclosed is an analysis of the Sickness Insurance Bill sponsored a few years ago by the American Association for Social Security, which probably contains the type of information you want. The statistical data in the "Supplementary Information" of this analysis indicate the type of calculations that are necessary.

The following is also offered as some help in answering your specific questions:

1. Enclosed are two lists of studies of physicians' income showing the median and average income during the past several years. Also enclosed is a clip sheet from *The Journal* of the latest report by the Department of Commerce. From these several studies you will be able to approximate the average or median income of physicians. A recent study by the National Bureau of Economic Research concludes that during the period of 1929 to 1934 the incomes of physicians averaged $4,100 annually.

2. You will notice that these lists of the studies of physicians' incomes include the study by the San Diego County Society for 1933 and the California Economic Survey for the period 1929 to 1934. These studies give some hint of the level of physicians' incomes in the State of California.

3. In regard to this question it might be first observed that the proposed amendment undertakes to include all persons in employments as defined in Section 6.5 and Section 7 of the Unemployment Reserves Act with the two exceptions specified in Section 153 of the proposed amendment. The scope of the amendment in designating the persons from whom contributions may be expected, to be paid either by the worker, the employer, or later by the State, is so wide that it would virtually include all persons in the State of California. However, your question "How many citizens in the State of California would come in the group of annual salaries between $840 and $3,000 per year?" can be answered to a certain extent. We take it you mean residents of California, not necessarily citizens.

A study by Margaret Kelm, "Medical Care and Costs in California Families in Relation to Economic Status," published by the State Relief Administration of California in 1935, includes an analysis of the incomes of selected samples of 5,096 low-income and wage-earning white families in California. From this selected sample it appears that 60 per cent of low-income and wage-earning white families in California would be included in the income class of $840 to $3,000 per year, according to present income levels. While the very poor sections and the very rich sections of the area surveyed were excluded, it may be that this

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† For complete roster of officers, see advertising pages 2, 4, and 6.

† The complete roster of the Committee on Public Relations is printed on page 2 of the front advertising section of each issue. Dr. George G. Reinle of Oakland is the chairman, and Dr. George H. Kress is the secretary. Component county societies and California Medical Association members are invited to present their problems to the committee. All communications should be sent to the director of the department, Dr. George H. Kress, Room 2004, Four Fifty Sutter Street, San Francisco.

Estimated Contributions Under the Proposed California Social Insurance Act, an Amendment to the Unemployment Reserves Act.

Income Class (Annual)	Estimated Income* (Thousands)	EMPLOYEES		EMPLOYERS		STATE	
		Tax (Per Cent)	Contribution (Thousands)	Tax (Per Cent)	Contribution (Thousands)	Tax (Per Cent)	Contribution (Thousands)
0-$ 840	$ 588,000	....	....	2	$11,760	1	$ 5,880
$ 840- 1,200	637,000	½	$ 3,185	1½	9,555	1	6,370
1,200- 2,400	1,666,000	1	16,660	1½	24,990	½	8,330
Over 2,400	2,009,000	1½	30,135	1	20,090	½	10,045
	$4,900,000		$49,980		$66,395		$30,625

* According to data in "America's Capacity to Consume," The Brookings Institution, pages 174 and 207, corrected according to United States Department of Commerce estimates of income in the United States.

Total estimated contributions equal $147,000,000, or 3 per cent of the total income of $4,900,000,000.

percentage distribution of family income would be somewhat representative of the majority of California families.

The California Medical-Economic Survey, with its records for 4,882 white families interviewed during an approximate year, 1934, also gives some indication of the income status of Californians. According to this study, 55 per cent of the families fell within the income group of $840 to $3,000.

From general studies of the distribution incomes, such as the reports of the Brookings Institution, the National Industrial Conference Board, and the Department of Commerce, it would seem that no fewer than 75 per cent of the individual persons and 69 per cent of all families would be included in the income group earning between $840 to $3,000 per year, in California.

4. In regard to your fourth point, it should not be overlooked that the proposed amendment undertakes to provide service benefits for all persons earning under $3,000 and not just the group earning between $840 to $3,000. Likewise, disability unemployment benefits and so-called reimbursement benefits are payable to persons earning more than $3,000 per annum. Disability unemployment benefits are also payable to persons earning less than $3,000 per annum. Consequently, it would appear that at least 90 per cent of the entire population would be eligible for some benefits under the proposed amendment.

5. The nearest possible estimate that could be made of the income in California from salaries and wages is $4,900,000,000. This is based on the geographic distribution of personal income from occupations as reported by the Brookings Institution for 1929, corrected to the level of income for 1937 according to the reports of the Department of Commerce.

It is impossible to know the number of persons who would be taxed under the proposed amendment or their incomes, but assuming that the total income from salaries and wages would be taxable under the amendment, the computation would be about as indicated in the accompanying table. It cannot be emphasized too much that all such computations are simply approximations, but it is believed that results are somewhat indicative of what may be expected. As shown in this table, the total money collected on and after July, 1941, would be approximately $147,000,000, or 3 per cent of the total income from salaries and wages. The contribution that employees, employers, and the State would probably make are shown in the table.

6. It is impossible to hazard a guess as to the average gross income that would accrue to the physicians under the proposed Social Insurance Act. The total fund collected under the Act must be used for so many diverse benefits that it is impossibel to know the amount that would be left for payment to physicians. Notice that out of the estimated $147,000,000 the benefits are payable for six categories of service benefits, one for maternity cash benefits and one for reimbursement benefits.

Particular attention should be called to the provision providing for disability unemployment benefits. The Interdepartmental Committee estimated that the cost of a disability compensation program would be 1 per cent of wages. Hence the disability unemployment benefits alone would require one-third of the total contributions.

Administrative costs would probably be not less than 15 per cent, if not more.

The probable cost of the benefits for hospitalization, drugs, medicines, and laboratory services is most uncertain, but would not be less than 25 per cent.

The cost of the reimbursement and maternity benefits cannot even be estimated.

However, from the foregoing it should be evident that the amount that would be left for payment to physicians would indeed be small. Which of the benefits would take preference cannot be determined from the amendment, but it seems fairly certain that the total contributions amount to but three per cent of the wages and salaries and will not be sufficient to provide for the grandiose system of benefits promised.

In regard to reimbursement benefits, it is rather curious that individuals earning more than $3,000 are considered as capable of spending their own money to obtain medical services but that persons earning less than $3,000 per year must have a paternalistic medical organization arranged for their medical services. It is not believed that the persons falling in this latter category would not want to be considered as unable to make their own purchases.

We trust that the foregoing will be of some help to you in your consideration of the proposed Social Insurance Act. Again it should be emphasized that all of the foregoing has been hastily prepared and should be considered as suggestions rather than as conclusions. . . .

GENERAL HOSPITALS AND THE WAGNER BILL*

Section 1201 of the Wagner Bill, Senate 1620, authorizes the appropriation in successive years of eight, fifty, and one hundred million dollars, respectively, for the construction and improvement of general hospitals. Under Section 1203 (a) (1), financial participation by the states is required. Naturally the extent of this participation will vary from state to state. Assuming, however, that the contributions of the Federal Government will be on a fifty-fifty basis, there will be available for the construction and improvement of government-owned general hospitals $16,000,000 in the fiscal year ending June 30, 1940, $100,000,000 in 1941, and $200,000,000 in 1942. Taking $4,000 as the average cost per bed of general hospitals, this bill would make provision for the addition of 4,000 general hospital beds in 1940, 25,000 general hospital beds in 1941, and 50,000 general hospital beds in 1942. These figures relate only to government-owned hospitals and do not include such enterprises, public or private, as may be undertaken without a Federal subsidy. Over an eleven-year period, 1928–1938 inclusive, the average annual increase in the number of beds in general hospitals was 1.9 per cent. The increases in number that are proposed in the Wagner Bill amount to a total of 79,000 beds, 16.2 per cent, in three years, or an average rate of increase of 5.4 per cent. In 1938 the general hospitals of the country were filled to 68.9 per cent of their capacity; 31.1 per cent of the beds were unused. Wherein lies the justification of the proposal to multiply threefold the normal increase of hospital facilities?

ORANGE COUNTY MEDICAL SOCIETY CIRCULARIZES EMPLOYERS OF LABOR

Text of the circular letter:

TO EMPLOYERS OF LABOR:

Increased Taxes, Increased Bookkeeping, Increased Overhead

There are before our legislators two Administration COMPULSORY Health Insurance bills (Assembly Bill No. 2172 and Senate Bill No. 1128). These bills provide that a tax, the major portion of which is paid by employers (based upon employees' salaries) be levied to provide employees and their dependents with medical, surgical, hospital, dental, drug and nursing services under political dictation.

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* Concerning Wagner Bill, see page 380.

This will mean another heavy expense to the employer. Taxes are high enough today without this unnecessary increase. These bills provide for another European experiment in social economics. They are dictatorial, un-American, political, regimental, and apparently un-Constitutional.

The Senate hearing occurs on April 4 and 5. If you do not want an increase in your pay-roll, bookkeeping and overhead, write or wire your Assemblyman to VOTE NO on Assembly Bill No. 2172, and your Senator to VOTE NO on Senate Bill No. 1128. Also send a copy of your letter or wire to Governor Olson.

Protect your employee's right to choose his doctor.

THE EXECUTIVE LEGISLATION COMMITTEE,
ORANGE COUNTY MEDICAL SOCIETY.

COMPULSORY HEALTH BILLS

The Public Health League of California on April 6, 1939, issued an interesting circular under the following captions:

DANGER!

KEEP EUROPEAN REGIMENTATION OUT OF CALIFORNIA

Stop Assembly Bill 2172; Senate Bill 1128

Prevent Medical Dictatorship!

"Isms" Won't Work in America!

Text of the circular follows:

Assembly Bill 2172 and Senate Bill 1128 provide a system of socialized *compulsory* medical care which originated in Germany. Despite the failure of this plan there and elsewhere, some California politicians are trying to subjugate the working people of this state to the same galling yoke of public medical care at an estimated cost of $70,000,000 a year, much of which would be *deducted from employees' pay rolls!*

* * *

Under the *"panel service"* plan contained in A. B. 2172 and S. B. 1128 the present confidential relationship of doctor and patient would be destroyed. *Your intimate personal and family medical records would become public property!*

* * *

In Europe, where compulsory medicine is the law, doctors frequently examine thirty patients in an hour—an average of two minutes to each patient. Do you want to be herded like cattle when illness takes you to a doctor's office?

You have paid large sums to the Unemployment Reserve Fund. These funds are held *in trust for you* to provide bare necessities in case of another economic depression—*The proponents of these bills propose to use unemployment funds*—thus *diverting your* reserve funds for more political jobs. *Do not allow tampering with your Unemployment Reserve Funds.* Cash disability benefits could be given now from these funds without saddling the state with a tax-eating system of compulsory medical care.

* * *

Staggering tax burdens and vast bureaus of government employees have been the net results of compulsory medical care in Europe. S. B. 1128 and A. B. 2172 propose to start in California by deducting up to 1½ per cent of the salary of every worker (except those earning $70 a month or less) making up to $3,000 a year. These bills provide taking 2 per cent of the total payroll in this classification from the employers also. In addition, conservative estimates place the remaining cost to the state at $36,000,000 a biennium—*and you would pay this huge amount in taxes, too!*

* * *

Write or telegraph your state senator or your assemblyman, or both, to vote No on A. B. 2172 and S. B. 1128. (Your local newspaper can give you the names of your senator and assemblyman. Address both at State Capitol, Sacramento.)

* * *

Compulsory Medical Care has been *repudiated* in New York, New Jersey, Massachusetts and other states after careful and thorough investigation.

The people of California don't want it!

* * *

The doctors of California don't want it!

Investigation of those supporting A. B. 2172 and S. B. 1128 show that those who do want compulsory medical care are almost without exception politicians—these bills would create thousands of political jobs *at our expense.*

* * *

It would not help indigents—they get free medical care.

It would not help the wealthy (those making over $3,000 a year), as they would not be included in compulsory care and would continue with their own doctors anyway.

It would not help the salaried man who would pay the taxes, lose his present personal relation with his physician and become one of the crowd rushed through the panel doctor's office.

* * *

Write your senator and assemblyman to vote No on A. B. 2172 and S. B. 1128.

Have your friends do likewise.

PUBLIC HEALTH LEAGUE OF CALIFORNIA

Issued April 6, 1939

ASSEMBLY BILL 2172 AND SENATE BILL 1128

Informative Bulletin—A

1. *By Whom Sponsored.*

Assembly Bill 2172 and its companion, Senate Bill 1128, are said to be "Administration" Bills. According to the newspapers, these bills are sponsored by and supported by Labor's Non-Partisan League and "a number of Liberal organizations."

2. *Why the Tie-In with Unemployment Funds?*

They establish a system of health insurance within the system of Unemployment Reserves. There is now $130,000,000 reserve in the Unemployment Fund contributed by employers and workers as a sacred trust against unemployment. This new scheme plans to tap this unemployment reserve fund and use it for health insurance.

3. *"Regimentation" of Workers.*

The bills regiment every worker earning up to $3,000 per year. Employing units which at any time during year have any individual in employment come under plan. See Section 155.

4. *Additional Taxation Levies on Payrolls.*

In addition to the amounts already being deducted from the worker's pay check for Federal and State reserves, there will be deducted from ½ to 1½ per cent from their wages. The employer will have to contribute up to 2 per cent, which is added to his already heavy taxes. Beginning with July, 1941, the State must contribute as high as one per cent. This will add a large sum to our taxes. In 1941 the total payroll contributions for Federal Security plans, State Unemployment reserves, and health insurance will reach 9 per cent.

5. *Physicians Are Also Regimented—Arbitrary Assignment in Cases.*

Not only are all workers earning up to $3,000 per year regimented, but physicians and surgeons, dentists, nurses, and hospitals will be regimented. Every worker must select a physician and surgeon to supervise his health at all times. If he fails to make such selection, one is arbitrarily assigned to him.

6. *Indefinite Number of Patients to Be Assigned.*

There are no provisions for the amount of remuneration the physician is to receive, and Section 304 even gives the State the authority to fix the number of patients he may serve. An influential doctor might be assigned five thousand patients.

7. *The Diagnostic Center Scheme for Services of Specialists.*

X-ray, laboratory services, and specialists and consultants' services will be rendered in public centers or let under contract at rates fixed by the State.

8. *How Drug Stores Might Be Involved.*

Drugs and medicines may be purchased from any pharmacy which has agreed to sell them at prices fixed by the governing authority. It would be possible for a large chain to contract with the State at prices that would force the thousands of independent pharmacies out of business.

9. *Tremendous Power of the "Governing Authority."*

The governing authority has full power to fix remuneration for nursing, hospitalization, dentistry, etc. See Section 306.

The worker is given no guarantee as to what length of service he is to receive and is at the mercy of the governing authority. See Section 235.

10. *Tremendous Power of the "Medical Director."*

The scheme sets up a new State bureau known as the Bureau of Medical Service and places full administration of the health of all workers in the State earning up to $3,000 per year, and all doctors serving them, in the hands of a medical director.

11. *Insufficient Representation of the Medical Profession.*

Although medical men are presumed to be best fitted for advising on health administration and medical societies have been studying this problem for many years, they *are not* represented on the Advisory Council which assists the medical director. This Council is made up of three representatives of labor and two representatives of employers. When this Council acts in an advisory capacity to the Bureau of Medical Service, two physicians are added, but no physicians are on the Council when it assists the director in administering this vast scheme.

12. *Other Objections.*

Careful reading of the bills will bring out many more points which are of serious concern to all citizens of the State.

These bills would set up another new bureaucracy, add additional tax burdens to workers, employers, and all citizens in general and embark California on an untried scheme of social insurance. It is impossible to estimate the hundreds of millions of dollars that such a scheme will collect from workers, employers, and general taxpayers.

These bills are unnecessary because the physicians of the State have already voluntarily established a plan to provide hospital and medical care on a proper actuarial basis at reasonable rates.

SOME OBJECTIONS TO SENATE BILL 1128 AND ASSEMBLY BILL 2172

Informative Bulletin—B

1. *Revenues.*

The revenues possible under the schedule of taxation and pay roll deduction will not cover 50 per cent of the benefits promised.

2. There is no social or economic justification of a schedule which assesses directly such a small sum from the beneficiary, *i. e.*, 40 cents a month for a person making $80 a month—$2 for a person making $200 a month, for the maintenance of the health of his family.

3. *Panel System.*

The *panel system* has inherent defects which are repugnant to American medicine and to the American people, such as: the tendency for casual and hurried care, the disturbance of physician and patient relationship, the forced tying together of a contract basis of patient and doctor for a specified time, the tendency toward injudicious increased medication, etc.

4. *Capitation Systems.*

The *capitation fee system* encourages poor work, unnecessary attentions, sloughing off of all cases possible onto the clinic specialist or hospital, discourages preventive medicine, etc.

5. *Proposed Types of Physicians.*

The division of the profession into general practitioner and clinic specialist will lower medical standards, tend to make two distinct castes. (Now most so-called general practitioners limit themselves voluntarily to certain types of practice, approaching the complete specialist in ability.) Under this system, they will be required to take care of all conditions which the powers to be may decide constitute general practice, thus leveling them down to mediocrity in all fields.

6. *Morbidity and Mortality Rates in Foreign Countries.*

Morbidity and mortality rates are higher in compulsory health insurance countries.

7. *Who Chooses Specialist or Hospital.*

Patient will not be allowed to choose his specialist or hospital.

8. *"Governing Authority" Decides.*

(Section 235) There is no guarantee that the beneficiary will obtain the benefits promised him. The amount of service may be sharply curtailed by the governing authority.

9. *How Large Can Panel Be?*

The size of a physician's practice is under the control of the governing authority. There is nothing in the act to prevent this authority from allowing political favorites to have extensive practices and to sharply limit those whom the authority desires to punish.

10. *Public Competition to Private Laboratories.*

Laboratories (X-ray and pathological) and hospitals will be compelled to meet rates upon which publicly owned and tax-supported hospitals and laboratories can be operated.

11. *Existing "Groups" May Be Favored.*

Provision is made to allow perpetuation of clinics and groups such as Ross-Loos, etc., or others that may be formed, and the rate of remuneration will be decided by the governing authority, giving an open road to political control.

12. *Rights of Pharmacists May Be Endangered.*

The governing authority shall fix the price at which pharmacies may sell drugs. Chain stores will be the answer, or dispensing of drugs at the clinics.

13. *"Advisory" Board to Medical Department Lacking in Sufficient Medical Personnel.*

The representation of the medical profession in the control of this act is completely inadequate. The governing authority is composed of laymen. The medical director will be politically appointed. His advisory council of seven will have only one representative of the physicians, and one of medical schools.

14. *Hospitals Are Forgotten.*

The hospitals have no represenation at all.

15. *A New State Bureaucracy will Come Into Existence.*

The health of the State will be politically controlled, a new bureaucracy.

16. *Defects in Plan not Easily Remedied.*

The code, if unworkable, can only be changed by the Legislature, which meets every two years, and even then organized opposition must be overcome.

17. Increased taxation will further retard recovery.

18. *Voluntary Plan of State Medical Association a More Desirable System.*

The code will seriously handicap the California Physicians' Service which offers definite guarantee of services promised, preserves the high standard of medical care, and the relationship of the physician and patient as far as possible under any insurance set-up.

CALIFORNIA PHYSICIANS' SERVICE*

Informative Bulletins

Bulletin I

Contract agreements with the three great nonprofit hospital associations of California were reported recently by California Physicians' Service, clearing the way for prompt presentation to the public of a voluntary, low-cost, monthly prepayment plan for medical, surgical and hospital care.

The three hospital associations are the Intercoast Hospitalization Insurance Association, with headquarters in Sacramento; the Insurance Association of Approved Hospitals group in and surrounding the San Francisco Bay area and the Associated Hospital Service of Southern California, with headquarters in Los Angeles.

Formal signing of the contracts agreed upon has now been set and the next step in the plan of the licensed doctors of medicine in California to enable employed and other groups to secure medical, surgical and hospital care by the doctors and hospitals of their own choice will be signing of contracts with the groups of patient, or beneficiary, members.

Signing of the hospital contracts will make available to the beneficiary members the services of approximately 80 per cent of the hospitals in California, excluding government-owned institutions and those which do not provide full hospital service. California Physicians' Service officials stated, however, that all other hospitals will be welcomed into the comprehensive medical, surgical and hospitalization plan, provided their standards of operation are approved.

With more than 4,700 licensed doctors of medicine in California now professional members of California Physicians' Service, Dr. Ray Lyman Wilbur, president, said the goal will be 100 per cent membership of licensed doctors of medicine and of approved hospitals in order to give the broadest selection to beneficiary members.

California hospitals, segregated by counties, that are affiliated with the three hospital associations are listed below:

Los Angeles County.—California Hospital, Cedars of Lebanon Hospital, Good Samaritan Hospital, Methodist Hospital, Presbyterian Hollywood Hospital, Santa Fe Hospital, White Memorial Hospital, Long Beach Community Hospital, Seaside Memorial Hospital, Huntington Memorial Hospital, St. Luke's Hospital, Glendale Physicians and Surgeons Hospital, Glendale Sanitarium and Hospital, Alhambra Hospital, Compton Las Campanas Hospital, Inglewood Centinela Hospital, San Pedro Hospital, Huntington Park Mission Hospital, Artesia Hospital, Covina Hospital, Monterey Park Garfield Hospital, Long Beach Harriman Jones Clinic Hospital, Golden State Hospital, Pomona Valley Community Hospital.

San Bernardino County.—Redlands Community Hospital, Loma Linda Sanitarium and Hospital, Upland San Antonio Community Hospital.

Riverside County.—Riverside Community Hospital.

Orange County.—Orange St. Joseph Hospital.

Santa Barbara County.—Santa Barbara Cottage Hospital, St. Francis Hospital.

Ventura County.—Ventura Foster Memorial Hospital, Oxnard St. John's Hospital.

San Diego County.—San Diego Mercy Hospital, Paradise Valley Sanitarium and Hospital, La Jolla Scripps Memorial Hospital, San Diego Elwyn Hospital.

San Francisco County.—Children's Hospital, Dante Hospital, Franklin Hospital, Greens' Eye Hospital, Mary's Help Hospital, Mount Zion Hospital, St. Joseph's Hospital, St. Francis Hospital, St. Luke's Hospital, St. Mary's Hospital, San Francisco Polyclinic Hospital, Stanford University Hospital, University of California Hospital.

Alameda County.—Alameda Sanatorium, Alta Bates Hospital, Berkeley General Hospital, Children's Hospital of the East Bay, East Oakland Hospital, Peralta Hospital, Providence Hospital, Samuel Merritt Hospital.

Marin County.—Ross General Hospital, San Rafael Cottage Hospital.

Contra Costa County.—Antioch Hospital, Concord Hospital, Martinez Community Hospital, Richmond Cottage Hospital.

Sonoma County.—General Hospital of Santa Rosa, Healdsburg General Hospital, Petaluma General Hospital, Sebastopol Hillside Hospital, Sonoma Burndale Hospital, Eliza Tanner Hospital.

Sutter County.—Yuba City General Hospital.

Butte County.—Chico Enloe Hospital, Oroville-Curran Hospital, Chico Hospital.

Yuba County.—Marysville Rideout Memorial Hospital.

Yolo County.—Woodland Clinic.

Placer County.—Auburn Highland Hospital, Auburn Landis Hospital.

Nevada County.—Grass Valley W. C. Jones Memorial Hospital.

Eldorado County.—Placerville Sanitarium.

Calaveras County.—San Andreas Hospital.

Tuolumne County.—Sonora Hospital, Sierra Hospital.

Stanislaus County.—Newman Hospital, Oakdale Hospital, Robertson Hospital, St. Mary's Hospital, Turlock Lillian Collins Hospital, Emmanuel Hospital, Modesto McPheeters Hospital.

Sacramento County.—Mercy Hospital, Sutter Hospital.

San Joaquin County.—Stockton Dameron Hospital, St. Joseph's Home and Hospital, Lodi Mason Hospital, Lodi Buchanan Sanitarium.

Tehama County.—Red Bluff Mercy Hospital.

Lake County.—Upper Lake Hospital.

Mendocino County.—Ukiah General Hospital.

Humboldt County.—Arcata Trinity Hospital, Eureka St. Joseph's Hospital.

Napa County.—Vallejo General Hospital, Napa Victory Hospital, Calistoga General Hospital.

San Mateo County.—Mills Memorial Hospital.

Santa Clara County.—O'Connor Sanitarium, Palo Alto Hospital, San Jose Hospital, Wheeler Hospital.

Santa Cruz County.—Hanly Hospital, Santa Cruz Hospital, Watsonville Hospital.

Monterey County.—Community Hospital, Park Lane Hospital, Peninsula Community Hospital, Salinas Valley Hospital, The Monterey Hospital.

San Benito County.—Hazel Hawkins Memorial Hospital.

Merced County.—Merced Mercy Hospital, Los Banos Hospital, Los Banos Emergency Hospital, Dos Palos Community Hospital.

Madera County.—Madera Dearborn Hospital, Madera Sanitarium.

Fresno County.—Clovis Hospital, Fresno Burnett Sanitarium, Reedly Hospital, St. Agnes Hospital, Coalinga Hospital, Kingsburg Hospital, Coalinga Pleasant Valley Hospital, Sanger Sanitarium, Selma Sanitarium.

Tulare County.—Tulare Bellevue Hospital, Lindsey Hospital, Porterville Hospital, Tulare Hospital, Visalia Municipal Hospital.

Kings County.—Hanford Sacred Heart Hospital, Hanford Sanitarium.

Kern County.—Delano Hospital, Bakersfield Mercy Hospital, Bakersfield San Joaquin Hospital, Taft Community Hospital, Tehachapi Hospital.

* * *

Bulletin II

Voluntary group prepayment plans for low-cost medical service have achieved notable success in the United States within recent years along lines similar to that of California's plan embodied in the California Physicians' Service, Dr. Ray Lyman Wilbur said recently.

"Although California doctors of medicine are the first group to launch a voluntary plan for low-cost monthly prepayment medical, surgical and hospital care on a state-wide basis, they have as precedents the operation of voluntary programs elsewhere which indicate beyond question the voluntary system is practicable," said Doctor Wilbur, who is president of California Physicians' Service.

The King County, State of Washington, plan was referred to by Doctor Wilbur in support of his statement. A voluntary service for medical, surgical and hospital care was started there six years ago and at present numbers more than 30,000 beneficiary, or patient, members.

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* Address: 220 Montgomery Street, San Francisco. Telephone: EXbrook 3212.

"More than half the members of the King County plan are in the low-income group, in fact, earning between $65 and $75 a month," Doctor Wilbur said. "Yet these members have voluntarily joined the service and made their monthly payments in anticipation of illness or accident. Proof of their satisfaction is given by the steady growth of the service. The doctors, on the other hand, have found that application of the plan has greatly widened their field of service to the people."

Doctors in Missouri are now engaged in organization of a voluntary group medical care plan similar to that of California Physicians' Service and thus will be in all probability the second state-wide group in the United States to inaugurate this modern medical care plan, Doctor Wilbur said.

COUNTY SOCIETIES

HUMBOLDT COUNTY

The Humboldt County Medical Society met on April 14 at the St. Joseph Hospital in Eureka at 8:30 p. m. Dr. Samuel P. Burre, President of the Society, presided.

Dr. Jacob Smith of the University of California Medical School surgical staff gave a very interesting discussion on *Gastric Surgery*. His dissertation was illustrated by x-ray films, photographs, lantern slides, and blackboard sketches. Doctor Smith took up the various methods of diagnosis and explained the advantages of the gastroscope for some cases. The operation of choice was pointed out in each particular type of case.

Saturday morning, at the Humboldt County Hospital, Doctor Smith conducted an operative clinic in which he did a gastric resection. Doctor Smith is an able teacher as well as operator, and we consider ourselves fortunate in having an opportunity to learn from him.

Proposed changes in the constitution and by-laws of our medical society were read for the first time. A committee of three was appointed to formulate plans to combat subversive legislation. Dr. W. J. Quinn gave a report on his recent trip to Sacramento and discussed bills detrimental to the welfare of the medical profession.

J. S. Woolford, *Secretary*.

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KERN COUNTY

The Kern County Medical Society held a dinner meeting at the Taft Hotel, in Taft, on Saturday evening, April 22. Doctor Chester Mead presided at the meeting, which is held annually in Taft to enable the members of the Society to become better acquainted with the physicians practicing in the West Side. Nineteen members and guests were present.

Announcement was made by Dr. C. S. Compton regarding new plans for clinics at the farm workers' camps under consideration by the Agricultural Workers' Health and Medical Association. Dr. L. A. Packard reported on further developments of the California Physicians' Service. Sixty-two physicians in Kern County have applied for professional membership.

Dr. Lloyd Tarr introduced the speaker, Dr. C. M. Hyland, on the staff of the Children's Hospital, Los Angeles, in charge of the Serum Center. He spoke on the *Use of Immune Sera in the Treatment of Infections*. Doctor Hyland emphasized the value of convalescent serum as the best means of modifying and preventing measles and advised its use in children under three years of age and those who have had recent attacks of other diseases, such as pneumonia, whooping cough, childhood type of tuberculosis, etc., to reduce the mortality from the disease. Dosage is 5 cubic centimeters for a child under three, 10 to 15 cubic centimeters for older children and adults. In scarlet fever the use of immune serum has reduced the incidence of complications to 8 per cent in the Los Angeles General Hospital. Doctor Hyland stated that the contact rate is practically nil in children exposed to scarlet fever in the immunized group and 18 per cent in the nonimmunized group. The scarlet fever serum also has been used with good results in streptococcic pneumonia, postpartum septicemia and in various streptococcic septicemias. The speaker also advocated the use of convalescent serum in the treatment of poliomyelitis, in spite of recent reports casting doubts on its efficacy. In the treatment of surgical shock, prolonged vomiting, diarrhea, severe burns, and other conditions which lower the blood serum proteins, Doctor Hyland recommended using dried human blood serum, which may be administered in Ringer's solution or with glucose.

Following a long discussion of the subject, the meeting was adjourned. C. S. Compton, *Secretary*.

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MENDOCINO-LAKE COUNTY

The April 1 meeting of the Mendocino-Lake County Medical Society was called to order by President Robert B. Smalley.

The speaker for the evening, Dr. George M. Uhl, Chief of the Bureau of County Health Work, Department of County Health, spoke on the subject of *The County Health Officer*. The duties of the full-time health department were explained. The advantages of a highly integrated county health program were enumerated. The actual cost of the present health program, with part-time health officers, was presented. Doctor Uhl felt that for little additional cost the full-time health program could be inaugurated.

The subject was discussed by Dr. H. O. Cleland, the present county health officer. He urged that the present facilities be utilized, though changes to a full-time department might be contemplated for the future.

The Secretary reported on letters sent to our State Senator and Assemblymen relative to the Compulsory Health Insurance bill. The California Physicians' Service was then discussed, and the members of the Society were found to be coöperating fully in joining.

Application for membership by Dr. William J. Perry of Willits was received.

Application by Dr. H. O. Cleland of Ukiah for membership was accepted pending a formal request.

It was desired that the dinner meetings as held in the past with the wives be dispensed with to allow more time for routine business matters. The time of the next meeting was tentatively set for July, to be held in Willits.

Dallas L. Wagner, *Secretary*.

⁂

SACRAMENTO COUNTY

The regular meeting of the Sacramento Society for Medical Improvement was called to order by the president, Dr. Manuel Azevedo, in the Auditorium at Twenty-ninth and L streets, on February 2.

Dr. Frank Lee presented a case of a boy nineteen years of age with a congenital heart lesion. An interesting case discovered accidentally during an examination for entrance to a C. C. C. camp. The boy has been doing heavy work. Doctor Lee asked the speaker of the evening to discuss the case.

The paper of the evening was presented by Dr. A. Christie, Instructor in Pediatrics at the University of California. Doctor Christie presented a very interesting talk on *Heart Disease in Children*. Discussion was opened by Doctor Babcock and continued by Dr. F. Reardan.

The applications for new membership of Drs. W. Harding, A. M. Henderson, Jr., and J. Dillon were read for the second time and voted upon. All were elected to membership. The applications of Drs. A. A. Atkinson, Lewis Specker, E. Blunden, and Pearson Kellogg were read for the first time.

Dr. F. Gundrum discussed the matter of postgraduate conferences in this area. The matter was referred to a committee, composed of Drs. M. Azevedo, D. Saeltzer, and G. Millar.

Doctor Dozier made a motion that the Board of Directors or the Secretary be instructed to invite Doctors Dukes and Kilgore to address the Society at a future meeting regarding the California Physicians' Service. Passed.

Doctor Cordes Ankele reported for the Banquet Committee. G. E. Millar, *Secretary.*

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SAN BERNARDINO COUNTY

The meeting of the San Bernardino County Medical Society was held at the Loma Linda Sanitarium in Loma Linda on Tuesday, March 7. Dinner was served at 7:30 p. m., with about eighty-five members and guests present.

The applications for membership of Dr. Elmer O. Carlson of Ontario and Dr. H. S. Eldredge of Lake Arrowhead were favorably voted upon.

Dr. W. W. Roblee, President of the California Medical Association, made a short address regarding *compulsory health insurance bills now before the State Legislature,* and urged physicians to join the California Physicians' Service to aid in defeating these highly undesirable bills.

Doctor Folkins introduced Dr. Margaret Sheerer of the University of California, who is making a survey of rheumatic fever in Redlands. Doctor Sheerer asked for the coöperation of the physicians.

The Chairman then introduced Doctor Butterfield, Superintendent of the Sanitarium, who introduced the speakers on the following program: *Clinical and Pathological Conferences in Cases of Jaundice,* by Dr. Newton Evans, Director of Laboratory of Los Angeles General Hospital, and Professor of Pathology of the College of Medical Evangelists; and *Value and Applications of Fever Therapy,* by Dr. Fred B. Moor, Professor of Pharmacology and Therapeutics, College of Medical Evangelists.

Arthur E. Varden, *Secretary.*

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SAN JOAQUIN COUNTY

The regular meeting of the San Joaquin County Medical Society was held on April 6 in the Medico-Dental clubrooms in Stockton. The regular meeting was preceded by the customary supper meeting at the Hotel Wolf at which there were seventeen present. Doctor Barnes spoke on *Early San Joaquin County Physicians.* The regular meeting was called to order at 8:30 p. m. by President Neill P. Johnson.

Dr. Dewey Powell gave an outline of the *work done by the Legislative Committee.* He spoke on *the importance of concentration effort to defeat the Administration Bill for Health Insurance* and stated that he had been requested by the Nurses' Association to appear at Sacramento to speak in favor of the Nurses' Licensary Bill. Because of the stand taken by the California Medical Association against this bill, he made the following motion, which was seconded by Doctor Doughty: That the Secretary be instructed to write to the California Medical Association asking them to change their policy on the Nurses' Bill or to give sufficient reason to the local society for not changing this policy and reasons for Doctor Powell not appearing to speak in favor of the Nurses' Bill. The motion was carried.

Doctor Powell outlined the progress that has been made by the California Physicians' Service in signing up professional members. Up until last night there had been sixty-six members signed up from San Joaquin County. This represents approximately two-thirds of the members in active practice.

The Membership Committee was called upon for a report and Doctor Rixford, Chairman, reported progress. The new By-Laws Committee was called upon for a report and Doctor Eccleston, Chairman, reported progress.

President Johnson announced that Doctor Teel would be in Stockton to speak on April 19. Doctor Teel is from the Harvard obstetrical staff, and his paper will be under the auspices of the Postgraduate Committee.

There being no further business to come before the Society the topic of the evening was then presented by Dr. Delbert Hand of Stanford. Doctor Hand presented a very interesting paper on the *Treatment of Non-Union in Fractures.* This was illustrated by drawings and x-ray films.

The meeting was adjourned at 9:30 p. m. and refreshments were served. G. H. Rohrbacher, *Secretary.*

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SAN MATEO COUNTY

The meeting of the San Mateo County Medical Society was held in the banquet room of the Benjamin Franklin Hotel on March 22, with Dr. N. D. Morrison presiding.

The Chairman announced that Dr. William Roscoe Jepson had been elected to membership in the Society at the last meeting of the Board of Directors. The Chairman further announced that Dr. Alfred Goldman had been elected to associate membership in the Society.

The Secretary made an announcement concerning the present status of the bills for compulsory health insurance now before the State Legislature and mentioned the work of the Speakers' Bureau on this subject. Display boxes of the pamphlet, entitled "Family Doctor or Federal Agent," prepared by Medical Economics, were distributed to the members of the Society, who are requested to place this material in their waiting rooms.

The Chairman then introduced the first speaker of the evening, Dr. Charles Weiss of Mount Zion Hospital, who presented a paper and slides on the subject, *Current Views on Staphylococcus Infection and Immunity.* Doctor Weiss' paper represented a distinct contribution to the problem of control of staphylococcus infections, with especial reference to the use of staphylococcus antitoxin. The second speaker, Dr. John Cline, was introduced by the Chairman, and he presented a discussion on the subject, *The Clinical Application of the Staphylococcus Immunity Reaction.* Doctor Cline discussed the use of staphylococcus toxoid in superficial infections, and in the discussion period following he made mention of results of work with sulfapyridin, the new chemical agent which shows promise of becoming an important adjunct in the treatment of staphylococcic infections. The papers of Doctors Weiss and Cline were received with great enthusiasm by the Society.

J. Garwood Bridgman, *Secretary.*

⁂

VENTURA COUNTY

The regular monthly meeting of the Ventura County Medical Society was held at the Saticoy Country Club on Tuesday, January 10.

President Mosher introduced Dr. Elmer Belt of Los Angeles, who gave a very interesting and instructive talk on *Gonorrhea and Its Complications.* Doctor Belt introduced Doctor Folkenberg of Los Angeles, who discussed the *Treatment of Gonorrhea by Sulfanilamide and Heat*; he also presented the latest methods for culturing the organisms.

The following communications were read: From Committee on Scientific Work regarding a booth devoted to plans and photographs of modern offices of physicians; from the State Medical Library, Los Angeles Division, in regard to journals available; from the Los Angeles Society of Ophthalmology and Otolaryngology regarding a proposed legislative bill to license and regulate dispensing opticians.

Doctor Smolt made a motion that the Society endorse a bill to license and regulate dispensing opticians in the State of California, and that such a bill be presented at the present legislative session at Sacramento, and that the secretary of the California Medical Association be informed by letter. The motion was seconded by Doctor Coffey and was unanimously carried.

After a brief discussion Doctor Shore made a motion that the Society request the Council of the California Medical Association to set up a unit of the California Physicians' Service in this district as soon as expedient. The motion was seconded by Doctor Strong, and carried.

Doctor Shore made a motion that Dr. Louis Packard of Bakersfield be suggested to the Board of Directors of the California Physicians' Service. The motion was seconded by Doctor Smolt and was unanimously carried.

Dr. C. R. Bennett of Camarillo State Hospital was unanimously elected to membership.

The following committee was appointed:

Publicity: Doctors Coffey (chairman), Nelson, Harker, Drace, and Morrison.

At the next monthly meeting Judge Henderson will speak on *Medical-Legal Problems.*

* * *

A special meeting of the Ventura County Medical Society was held at the Saticoy Country Club on Monday, January 23.

President-Elect C. A. Dukes, Secretary George H. Kress of the California Medical Association, and L. A. Packard, Councilor of the Third District, addressed the Society on *California Physicians' Service and other problems of the California Medical Association.*

There was no business meeting.

* * *

The regular monthly meeting of the Ventura County Medical Society was held at the Saticoy Country Club on Tuesday, March 14.

Doctor Boyes gave a very fine illustrated talk on *Infections of the Hands and Their Treatment.*

Mr. Hadenger of Lloyd's spoke on *The History of Malpractice Insurance.* Mr. Reed gave some of the *Legal Aspects and Causes of Suits.*

A report of the Secretaries' Conference was given by the Secretary.

The addition of another physician to work under Doctor Wylie in the Health Department and help with the examination of school children in the outlying districts was discussed. As the hour was late and discussion did not seem to be accomplishing anything, Dr. W. S. Clark made a motion that the matter be tabled. The motion was seconded by Doctor Nielsen, and carried.

Doctor Homer made a motion that a vote of thanks be given Doctor Boyes for a splendid talk. The motion was seconded by Dr. W. S. Clark, and was unanimously carried.

A. A. Morrison, *Secretary.*

CHANGES IN MEMBERSHIP

New Members (67)

Alameda County

J. A. Crane
Edward G. Ewer
Richard P. Johnson
Ann L. Martin
Eli R. Movitt
Ernst Windesheim

Butte County

Arthur E. Allen

Fresno County

V. E. Jeans
Fred Q. Jing
R. A. Schaumloffel
Maurice F. Stock
John Weber

Kern County

W. H. DeSmet
W. H. McDonald
J. T. Stanton

Los Angeles County

Otto Arndal
Louis Baltimore
J. Harold Cantarow
Harry L. Dixon
O. S. Hansen
H. P. House
John T. Klausner
Lillian Kositza
William L. C. MacBeth
Frederick D. Newbarr
Werner Rammelt

Marin County

Andrew E. Thuesen, Jr.

Mendocino-Lake County

William James Perry
E. H. Sawyer

Monterey County

H. M. Stufflebam
Frederick A. Veitch
Vera Wayman
J. J. Weir

Sacramento County

A. M. Henderson, Jr.

San Bernardino County

Robert N. Williams

San Diego County

Albert Ickstadt, Jr.
A. E. Moore
George W. Morris
Harrison S. Paynter

San Francisco County

Coleman A. Block
Leonid S. Cherney
Margaret H. Reese
John B. DeC M. Saunders (Associate)
William F. Wagner

San Luis Obispo County

Horace Hagen
Newell Nay
Albert Shershow

San Mateo County

William R. Jepson

Santa Barbara County

John W. Needles

Santa Cruz County

J. B. Cutter
J. C. Jacobson

Siskiyou County

Harry R. McVicker
Alex J. Otten

Solano County

Howard E. Gardner
Herman Henry
H. Randall Madeley

Sonoma County

Burton L. Zinnamon

Stanislaus County

Terry Laird
B. R. Pearson
Frank F. Schade

Tulare County

D. B. Cherry
Donald G. MacKinnon

Yolo-Colusa-Glenn County

Austin M. Clark
Charles Kelley Mills
John O. Raffety
John W. Rovane

Yuba-Sutter County

T. E. Larner

Transferred (12)

Gordon Bunny, from Santa Cruz County to Solano County.

George A. Foster, from Sacramento County to Placer County.

Harold F. Galbraith, from Los Angeles County to Ventura County.

Clarence T. Halburg, Jr., from Los Angeles County to San Bernardino County.

W. F. Harding, from Marin County to Sacramento County.

Robert A. Hare, from Santa Barbara County to Maryland State Association.

John E. Kirkpatrick, from Los Angeles County to Shasta County.

Edward S. Lodge, from Los Angeles County to Orange County.

Henry G. Mello, from Butte County to Alameda County.

Francis B. Sheldon, from Orange County to Los Angeles County.

B. W. Wright, from Los Angeles County to Tennessee State Association.

Dwight Dunham Young, from Los Angeles County to Orange County.

In Memoriam

Bollig, Harold Lewis. Died at Los Angeles, March 21, 1939, age 36. Graduate of the University of Nebraska College of Medicine, Omaha, 1929, and licensed in California the same year. Doctor Bollig was a member of the Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

✠

Hart, Horton Edwin. Died at San Francisco, March 23, 1938, age 57. Graduate of the University of California Medical School, San Francisco, 1904, and licensed in California the same year. Doctor Hart was a member of the San Mateo County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

✠

Lowell, George Clough. Died at San Anselmo, March 27, 1939, age 46. Graduate of the University of California Medical School, San Francisco, 1936, and licensed in California the same year. Doctor Lowell was a member of the Marin County Medical Society, the California Medical Association, and the American Medical Association.

✠

Ormsby, Elon A. Died at Centerville, March 24, 1939, age 67. Graduate of the California Eclectic Medical College, Los Angeles, 1896, and licensed in California the same year. Doctor Ormsby was a member of the Alameda County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

✠

Scanland, John Milton. Died at Napa, March 14, 1939, age 65. Graduate of the College of Physicians and Surgeons, Baltimore, Maryland, 1897. Licensed in California in 1925. Doctor Scanland was a member of the Napa County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

THE WOMAN'S AUXILIARY TO THE CALIFORNIA MEDICAL ASSOCIATION[†]

MRS. CLIFFORD A. WRIGHT..............................President
MRS. FRED H. ZUMWALT..............Chairman on Publicity
MRS. FRANK H. RODIN..Assistant Chairman on Publicity

News Letter

Dear Auxiliary Members:

As the fiscal year draws to a close, we wish to congratulate and thank the officers, chairman and members of each County Auxiliary who have served loyally and have given their best efforts in carrying on the program of education, service and friendship.

May I, as assistant publicity chairman, join Mrs. Fred H. Zumwalt in thanking each and every one who has so efficiently helped during the year by sending in the material used for publicity. Your coöperation has been very valuable and helpful. It has been a privilege and a pleasure to serve you.

To the newly elected officers and chairmen our best wishes for success. The value of the auxiliaries to the county medical societies is being recognized and appreciated through the faithful service, coöperation and understanding given by the members of the auxiliaries.

Reports and convention activities will be published in the following issues of the CALIFORNIA AND WESTERN MEDICINE.

Sincerely yours,
MRS. FRANK H. RODIN.

Component County Auxiliaries

Alameda County

Unusually successful was the Annual Student Loan Fund party given in March by the members of the Woman's Auxiliary to the Alameda County Medical Association.

Over five hundred women met for luncheon at the Claremont Country Club, and to admire the beautiful gowns and costumes modeled by the following charming members: Mesdames Thomas Clark, A. S. Alexander, Dudley Smith, Grant Ellis, Gordon Roberts, C. B. Fowler, Chelsea Eaton, Maxwell Thebaut, James Barr, George Nesche, and J. B. Hollingsworth.

Mrs. William Sargent presided at the microphone and introduced each model as she appeared and walked down the aisle to the soft music of the orchestra.

After the fashion show, bridge was enjoyed by the members and guests. Rose bushes were presented as prizes to the winners at each table.

In keeping with the season, spring flowers in all their glory were in evidence everywhere.

Appreciation and thanks is extended to the very capable chairman of arrangements, Mrs. Wallace Partch. And to Mrs. George Mainwaring, chairman of the fashion show; Mrs. Forest Kracaw, luncheon chairman; Mrs. Grant Ellis, publicity chairman; Mrs. Richard Young, chairman of reservations and Mrs. Suren Babington, bridge chairman.

MRS. GRANT ELLIS, *Publicity Chairman.*

[†] As county auxiliaries of the Woman's Auxiliary to the California Medical Association are formed, the names of their officers should be forwarded to Mrs. Frank H. Rodin, Assistant Chairman of the Publicity and Publications Committee, 2457 Bay Street, San Francisco. Brief reports of county auxiliary meetings will be welcomed by Mrs. Rodin and must be sent to her before publication takes place in this column. For lists of state and county officers, see advertising page 6. The Council of the California Medical Association has instructed the Editor to allocate two pages in every issue to Woman's Auxiliary notes.

Fresno County

The addition of thirteen new members to the Woman's Auxiliary to the Fresno County Medical Society was reported by Mrs. W. F. Stein, vice-president and membership chairman. This is outstanding evidence that the doctor's wives are realizing the value of the Woman's Auxiliary.

Thirty members were present at the meeting held April 4, at the University Sequoia Club. Mrs. Otto Dederich, a member of the Auxiliary, reviewed the book *Consultation Room,* by Dr. Frederick Loomis.

Mrs. Charles H. Ingram, *Publicity Chairman.*

⁂

Los Angeles County

The members of the Woman's Auxiliary to the Los Angeles County Medical Association met for luncheon, March 28, at the County Medical Building. The president, Mrs. William H. Leake, presided with 105 members and guests present.

After the business meeting, Dr. George D. Maner, a member of the Committee for Pneumonia Control of the California Medical Association, gave an interesting talk on the *Diagnosis and Treatment of Pneumonia.*

Drs. John Fleude and Clarence Toland spoke in behalf of the drive for the *Control of Cancer,* illustrated by a film entitled *Fight Cancer With Knowledge.*

Mrs. Karl Von Hagen, *Publicity Chairman.*

⁂

Marin County

The March meeting of the Woman's Auxiliary to the Marin County Medical Society was held at the Sleepy Hollow Golf Club.

Twenty-four members met for dinner. After the business meeting Mrs. C. A. De Lancey read a play entitled *Charity Begins at Home.* The play was approved and members of the Auxiliary are rehearsing the parts and the play will be presented at the May meeting for the entertainment of their husbands and friends.

Mrs. C. A. De Lancey, *Publicity Chairman.*

⁂

Monterey County

The Woman's Auxiliary to the Monterey County Medical Association is again happy to have been the hostesses to the members and guests of the woman's auxiliaries who attended the convention of the California Medical Association in Del Monte.

A very active year is reported as follows:

In January a card party at the House of Four Winds in Monterey, the proceeds were used to supply furnishings for the children's tuberculosis unit of the Monterey County Hospital.

In February the members met for luncheon at the Santa Lucia Inn at Salinas.

In April, the retiring president, Mrs. Garth Parker, was the hostess to the members of the Auxiliary at a luncheon at her home.

The newly elected officers are: president, Mrs. A. A. Arehart; vice-president, Mrs. Herbert Archibald; secretary, Miss Elizabeth Merrill, and treasurer, Mrs. G. Eberhardt.

Mrs. A. A. Arehart, *Publicity Chairman.*

⁂

Orange County

The Woman's Auxiliary to the Orange County Medical Society honored three state officers at their March meeting, held at the home of Mrs. G. Wendell Olson. The visiting guests were Mrs. Clifford A. Wright, president; Mrs. E. Eric Larson, secretary, and Mrs. Arthur T. Newcomb, councilor and librarian of the California Woman's Auxiliary.

After the business meeting the program chairman, Mrs. K. H. Sutherland, introduced the guests who spoke on the various activities of the Woman's Auxiliary.

Mr. E. E. Smith of Anaheim spoke on the *Life of Johannes Brahms,* German music composer, and Mrs. Dana Newkirk played several of Brahms compositions.

Mrs. Olson was assisted during the tea hour by Mesdames Harold Gobar, Dale Petteplace, Edwin Kersten and C. F. W. Kohkenberger.

Mrs. G. Wendel Olson, *Publicity Chairman.*

⁂

Riverside County

Mrs. James F. Percy, revisions chairman of the National Auxiliary and parliamentarian of the State Auxiliary, was the guest speaker at the February meeting of the Riverside County Auxiliary. Mrs. Percy discussed the *Aims and Problems of the Auxiliary,* and traced the development of Socialized Medicine in the United States and the part that the doctor's wives should play in the present situation.

The president, Mrs. W. W. Roblee, presided at the meeting, which was held at the home of Mrs. Erwin Miller.

After the meeting the doctors joined their wives for refreshments and entertainment. Mrs. Charles Miller played several of her own compositions on the piano.

Assisting the hostess, Mrs. Erwin Miller, were Mesdames W. K. Templeton and O. M. Wheeler.

* * *

In March the president, Mrs. W. W. Roblee, assisted by Mrs. George W. Coon, was hostess to the members of the Woman's Auxiliary to the Riverside County Medical Society at a very delightful luncheon at her home. About twenty members and guests were present.

After a short business meeting, Mrs. F. G. Lindemuller, chairman of public relations of the San Diego County Auxiliary, gave a most interesting talk on *Practical Problems of the Auxiliary.*

Mrs. T. A. Card, *Publicity Chairman.*

⁂

San Diego County

The Woman's Auxiliary to the San Diego County Medical Society welcomed back their president, Mrs. C. O. Tanner, on her return from a trip to Europe.

Mrs. Tanner presided at the meeting in March, which was held at the University Club.

Very gratifying was the report on the annual bridge benefit. The final arrangements for the annual spring dinner dance were made.

Mrs. H. K. Albertson, *Publicity Chairman.*

⁂

San Francisco County

The members of the Woman's Auxiliary again invited their husbands and members of the San Francisco County Medical Society to a Valentine dinner dance, held in the beautiful home of the Medical Society.

Mrs. William W. Newman was in charge of arrangements, assisted by the following committee: Mesdames Thomas E. Gibson, John Humber, Maurice Korshet, Bernard Cody, Charles Noble, Andrew Stockton, Robert Newell, Edmund Morrisey, Wilbur Swett, Frank Hand, George Becker, Maurice Eliaser, John Sampson and Fred D. Fellows.

Dr. Lawrence R. Custer was Master of Ceremonies. His accordion and entertaining manner were greatly enjoyed.

Mrs. Thomas E. Gibson, president of the Auxiliary, very graciously sang many selections accompanied on the piano by Dr. Clifford A. Dickey. The dialect stories of Drs. Ellsworth F. Quinlan, Donald deCarle, and Dudley Smith were very amusing and entertaining.

The lovely decorations of spring blossoms and flowers and the Valentine motives of red and white added much to the party spirit.

To complete the evening's entertainment, the guests enjoyed the art exhibit, shown in the ballroom, of paintings, sculpture, wood carvings, prints, and photography, etc., which were executed by doctors.

Mrs. Clain F. Gelston, *Publicity Chairman.*

⁂

San Joaquin County

The State President, Mrs. Clifford A. Wright, and her secretary, Mrs. E. Eric Larson, were the honored guests at a luncheon preceding the regular meeting of the San Joaquin County Auxiliary in February.

The meeting was held at the home of Mrs. Vern Ross. Mrs. Wright gave an interesting talk on *How the Doctors' Wives Can Be of Service in Their Community.*

Tea was served after the meeting and the nineteen members present enjoyed meeting the guests and a social hour.

Mrs. G. K. Wever, *Publicity Chairman.*

⁂

Santa Barbara County

Eleven health chairmen, representing various organizations, were the guests of the Woman's Auxiliary to the Santa Barbara County Medical Society at the March meeting, held at the home of Mrs. Frank J. Homback.

Dr. Susanne Parsons gave an interesting and enlightening talk on the *Work of the American Society for the Prevention of Cancer.*

The following officers were elected for the ensuing year: Mesdames Edward L. Markthaler, president; Richard McGovney, first vice-president; O. C. Jones, second vice-president; C. W. Henderson, recording secretary; P. A. Gray, corresponding secretary, and John Van Paing, treasurer.

Mrs. Alfred Wilcox, chairman of the Committee in Charge of Arrangements for the bridge tea, reported on the plans.

After the meeting, tea was enjoyed by the members and guests.

The members of the Auxiliary sponsored a musicale on Easter Sunday afternoon, the proceeds of which were contributed to the Cancer Control Campaign. Mr. Henry Eicheim, noted musician, arranged the program.

Mrs. C. W. Henderson, *Publicity Chairman.*

⁂

Santa Cruz County

Cure and Prevention of Tuberculosis was the subject presented by Dr. J. D. Fuller and Miss Lois Holworth, County Health Nurse, at the March meeting of the Woman's Auxiliary to the Santa Cruz County Medical Society.

Eleven members and two guests met for luncheon at the Appleton Hotel in Watsonville.

Mrs. R. C. Alsberg, *Recording Secretary.*

⁂

Tulare County

The Woman's Auxiliary to the Tulare County Medical Association held its March meeting in Visalia.

Mr. Combs, an attorney, gave a fascinating talk on *Books, the Print and Bindings,* and illustrated same with an interesting display.

Mrs. W. B. Parkinson, *Corresponding Secretary.*

First Pan-American Coöperation Was in Public Health Work.—"The interest, enthusiasm, and occasional criticism aroused by the eighth International Conference of American States at Lima, Peru, recently," says an editorial in *The Journal of the American Medical Association* for April 1, "offer opportunity to point out that when effective Pan-American coöperation in most matters was still a dream of statesmen and scholars it had already been achieved in the field of public health, largely under medical auspices.

"International coöperation of the American republics in this field began at the quarantine conference held in Washington in 1881."

Among the notable accomplishments of the Pan-American Sanitary Conferences, the first of which was held in 1902, was the approval of a Pan-American Sanitary Code in 1924, a model international health charter which was the first Pan-American treaty unanimously ratified by all the republics.

The tenth Conference, held in Bogotá, Colombia, in September, 1938, was one of the most successful because of the completeness of its program, the size and technical character of its delegations, and the extensive scientific reports submitted.

"The eleventh Pan-American Sanitary Conference is scheduled to be held in Rio de Janeiro, Brazil, in about four years and will be preceded by the fourth Pan-American Conference of National Directors of Health, to be held in Washington in 1940," the editorial reports.

"The American Medical Association lent effective and practical support to this movement through the publication of its Spanish edition for a period of ten years (1918-1928)."

Parents Should Pay More Attention to Children's Good Behavior.—If parents would pay more attention to their children's good behavior and ignore their bad conduct, temper tantrums would become much less frequent, William I. Fishbein, M. D., Chicago, suggests in the May issue of *Hygeia,* the health magazine.

When the child has a tantrum, Doctor Fishbein advises, "put him into a room where anything which he may destroy is out of reach, and leave him alone until the tantrum is over.

"Make sure that the child does not attain by the tantrum the object for which he is having it. Control your own temper. Do not scold the child nor punish him for the tantrum.

"Try to keep the legitimate reasons for the child's anger at a minimum. Interfere as little as possible with the child's natural activities. Correct improper behavior promptly with as little fuss as possible. Do not permit today what will be forbidden to morrow."

Any physical source of irritation should be discovered and remedied, Doctor Fishbein points out. However, many parents become unduly alarmed when an angry child holds his breath and becomes momentarily unconscious. "A child has never injured himself during such an attack, and if he is left alone, the breathing begins normally in a few seconds," the author says.

An epileptic attack may resemble breath holding, but a physician can easily tell the difference. Once the parent has been assured that the child does not have epilepsy, he should ignore the breath holding.

We are beginning to recognize that amusement . . . is a commodity as essential to the physical and mental health and well-being of the human animal as lumber, wheat, oil, steel, or textiles.—Milton Sills.

MISCELLANY

Under this department are ordinarily grouped: News Items; Letters; Special Articles; Twenty-five Years Ago column; California Board of Medical Examiners; and other columns as occasion may warrant. Items for the News column must be furnished by the fifteenth of the preceding month. For Book Reviews, see index on the front cover, under Miscellany.

NEWS

Coming Meetings

American Medical Association, St. Louis, Missouri, May 15 to 19, 1939. Olin West, M. D., Secretary, 535 North Dearborn Street, Chicago, Illinois.

California Medical Association, Hotel Del Monte, May 1 to 4, 1939. George H. Kress, M. D., Secretary, 450 Sutter Street, San Francisco.

Nevada Medical Association, Reno, September 22 and 23, 1939. Horace J. Brown, M. D., Secretary, P. O. Box 689, Reno, Nevada.

Medical Broadcasts *

Los Angeles County Medical Association

The radio broadcast program for the Los Angeles County Medical Association for the month of May is as follows:

Thursday, May 4—KECA, 10:45 a. m., The Road of Health.
Saturday, May 6—KFI, 9:00 a. m., The Road of Health; KFAC, 11:30 a. m., Your Doctor and You.
Thursday, May 11—KECA, 10:45 a. m., The Road of Health.
Saturday, May 13—KFI, 8:00 a. m., The Road of Health; KFAC, 11:30 a. m., Your Doctor and You.
Thursday, May 18—KECA, 10:45 a. m., The Road of Health.
Saturday, May 20—KFI, 9:00 a. m., The Road of Health; KFAC, 11:30 a. m., Your Doctor and You.
Thursday, May 25—KECA, 10:45 a. m., The Road of Health.
Saturday, May 27—KFI, 9:00 a. m., The Road of Health; KFAC, 11:30 a. m., Your Doctor and You.

The American Congress on Obstetrics and Gynecology.—The first American Congress on Obstetrics and Gynecology is to be held in Cleveland, Ohio, from September 11-15, 1939. This important meeting comes at a crucial time in American Medicine. The problems associated with human reproduction have become of paramount importance, arousing the intense interest of the public and the profession. The meeting will provide the first opportunity for all the interested groups of workers to assemble together. Doctors, nurses, hospital administrators and public health workers will meet and discuss their mutual problems and correlate their many ideas. A large and representative attendance is necessary to assure the success of this meeting. Already more than 1,400 advance registrations have been received.

We are anxious to have your JOURNAL participate in the medical publicity so that the physicians of your state can be apprised of the coming meeting. We have already had the support of many local and national medical publications. We would appreciate your official editorial comment concerning the meetings. If you could carry a notice of the meeting on the cover of your JOURNAL or in a prominent place in your future numbers, it would help considerably in creating interest among your physicians. Dr. T. Henshaw Kelly, your State Chairman and his committee will be delighted to coöperate with you in every way. For information, address M. Edward Davis, M. D., Publicity Committee, The Annex, 650 Rush Street, Chicago, Illinois.

The American Dietetic Association. — The twenty-second annual meeting of the American Dietetic Association will be held at the Hotel Ambassador in Los Angeles, August 27 through the 31st, 1939.

Miss Mary Northrop, King's County Hospital, Seattle, Program Chairman, has already received acceptances from several well-known West Coast speakers.

Agnes Faye Morgan, Ph.D., of the University of California, will speak on "The Dietitian's Place in the Hospital Research Program"; Albert H. Rowe, M. D., Oakland, will speak on "Allergy"; E. Neige Todhunter, Ph.D., State College of Washington, will talk on "The Newer Knowledge of Vitamin C in Health and Diseases." For further information, address the American Dietetic Association, 185 North Wabash Avenue, Chicago, Illinois.

American Academy of Ophthalmology and Otolaryngology. — The forty-fourth annual convention of the American Academy of Ophthalmology and Otolaryngology will be held in Chicago, October 8-13 at the Palmer House, a bulletin announces.

The academy has a membership of about 2,800 eye, ear, nose and throat specialists and the attendance at meetings is usually well over 2,000. It is said to be the largest organization of specialists in the United States.

About half the program is devoted to formal addresses, but fully half the week's activities consist of "instructional courses," in which the doctors go to school in earnest, with hundreds of eminent specialists as their instructors.

Dr. George M. Coates, Philadelphia, is president this year and Dr. Albert C. Snell, Rochester, New York, is president-elect. For information, address 1500 Medical Arts Building, Omaha, Nebraska.

1938 Said to Be Record Health Year.—The year 1938 is expected to establish an all-time record for low death rates from all causes in the United States, and particularly for tuberculosis, typhoid, diphtheria and infant mortality. This is set forth in a statement issued by the University of California Curricula in Public Health, prepared by Dr. Haven Emerson of the De Lamar Institute of Public Health of Columbia University.

"We are now in fact the possessors of better general health, are less afflicted with diseases known to be preventable, are more secure in the survival and growth of our offspring to maturity and have an average expectancy of life greater than that of any population group in the history of man," the statement said.

The statement suggests that the United States should further put its health house in order "by following the example of Canada and England and a score of other nations in consolidating all of their health services under one department, with a secretary for health in the national cabinet."

State and local health departments "are weary and bewildered by the duplicating and often conflicting proposals of unrelated bureaus and boards of Federal Government, each with ideas, standards and money grants with strings attached for health improvement," the statement said.

"That some people who need medical attention do not receive it will always be true, but the reasons for this are not all due to the inability of these sick to pay for the cost of necessary treatment. It may result from ignorance, superstitions and misinformation," the statement said.

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* County societies giving medical broadcasts are requested to send information as soon as arranged (stating station, day, date and hour and subject) to CALIFORNIA AND WESTERN MEDICINE, 450 Sutter Street, San Francisco, for inclusion in this column.

American Association of Industrial Physicians and Surgeons. — The twenty-fourth annual meeting of the American Association of Industrial Physicians and Surgeons with the American Conference on Occupational Diseases and Industrial Hygiene will be held at the Hotel Statler, Cleveland, Ohio, June 5, 6, 7, and 8, 1939. A program of timely interest and importance will be presented by speakers of outstanding experience in all of the medical and engineering problems involved in industrial health. A cordial invitation is extended to all whose interests bring them in contact with these problems. Information regarding hotel accommodations, etc., may be obtained from A. G. Park, Convention Manager, 540 North Michigan Avenue, Chicago.

Shock Therapy of Benefit But Needs Research.—The development of "shock" therapy for mental disorders is not at present the unbounded success that it has been called in some quarters, although it holds considerable promise and merits the continuation of active research. This is stated by Dr. Nolan D. C. Lewis, director of the New York Psychiatric Hospital, who visited here to advise with the University of California administration in the possible reorganization of the psychiatric services of the University's medical school here.

The use of insulin and the drug metrozol, an ally of camphor, as a therapeutic "shock" source in certain mental diseases has been found of benefit, Doctor Lewis said. However, it is necessary to confine the treatment to certain types of diseases and certain selected patients within these types, and extreme skill is necessary in both the selection of the patients and the administration of either drug, if untoward effects are to be avoided. When such care has been exercised the treatment may effect cures in 60 per cent of the cases treated.

The increase in mental patients has been rapid in the past few years for no exactly apparent reason, Doctor Lewis said. This increase has laid considerable new stress on the psychiatric and neurologic approach to disease in hospitals and has occasioned many new problems for the medical profession.

"We cannot lay this increase to economic unrest and the stresses and strains of life solely," Doctor Lewis said. "The average individual is being bombarded with new experiences and impressions which force him to live a lifetime in a few years. These developments are coming along apparently faster than the delicately balanced and highly organized human nervous system can handle them. It cannot properly integrate them in many instances apparently, and a breakdown follows.

"If the damage has not been too great, rest and a reversal of the former mode of life may be beneficial. Shock therapy is being tried in the more advanced cases with the results noted."

Endocrine Glands Subject of Special Course.—The human endocrine glands, sometimes called "the glands of personality," little masses of cells, controlling the emotions, love and sex, but which may also cause gigantism, dwarfism and other abnormalities, were made the subject of a recent short course for practicing physicians at the University of California Medical Center. The course was decided on in order to give the profession at large new information concerning these glands which has been developed in laboratories and research institutions in the last several months.

The glands are scattered throughout the body. From the blood these little masses of tissue abstract chemicals and transform them into secretions known as hormones. These hormones are poured back into the blood and the glands which produce them are therefore sometimes called glands of internal secretion. The thyroid gland largely governs the rate and completeness with which the oxygen we breathe unites with and burns up foodstuffs. The parathyroids and the adrenals govern, in part at least, the absorption and use of minerals in bones and other tissues. The gonads give the powers and evidences of femininity and masculinity. Parts of the pancreas guide the storage and burning up of sugar in the body. The pituitary, the most complicated of all glands, has been called the "master gland," for its hormones seem to be needed by the other glands if they are to function in a healthy manner. The pituitary has a powerful influence over growth.

The remarkable progress that has been made in the study of endocrine gland function, and the treatment of gland disturbances in the past few years were thoroughly reviewed in the course. The necessity of having a trained physician prescribe glandular extracts was stressed.—University of California Clip Sheet.

Press Clippings.—Some news items from the daily press on matters related to medical practice, follow:

Olson Backs Health Plan

Governor Olson last night devoted his regular Sunday night broadcast to a plea for the proposed compulsory state health insurance law—a measure which would burden California pay rolls with additional levies on both employer and employee.

The Governor pointed out the service would apply to all workers earning up to $3,000 annually and would be financed by a 1 per cent contribution from each worker's salary, plus contributions up to 2 per cent from employers.

He characterized the plan as "a central policy of my administration" and interpreted it as an economy measure in as much as it "will reduce the cost of relief by reducing sickness that finally makes wage earners destitute."—San Francisco *Examiner,* April 10.

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Health Insurance

In his talk broadcast Sunday, Governor Olson said his health program to be financed by a pay roll tax should be adopted because there is need of better health protection. There are many pressing needs, among them modern prisons to take the place of prisons making first offenders habitual criminals, provide hospital facilities for the insane, adequate aid to the blind and crippled to enable them to be self supporting. Yet they must be postponed because no government can satisfy all social needs.

The New Deal tried to do it, with the result tax burdens have become so heavy they exceed the capacity of industry to carry them. Measures designed to aid the ill-nourished, ill-clad and ill-housed, have made their condition worse because they reduced employment in private industry.

The most important welfare interest in California is restoring employment. Taxes are already so high many employers are compelled to reduce their employees to keep out of the red. Another pay roll tax for health would swell the ranks of the unemployed.

The people now have a health service equal to the best in the world. A voluntary group insurance program is being worked out to improve it. Assuming Governor Olson's health program to be desirable, it should be postponed until a sound recovery is achieved.—San Jose *Mercury-Herald,* April 11.

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Health Laws Urged

Olson Upholds Insurance Bills

Examiner Bureau, Sacramento, April 13.—Governor Culbert L. Olson today sent to the Legislature a strong recommendation for passage of two compulsory health insurance bills, drafted by Labor's Non-Partisan League and incorporated in the administration's legislative program.

Arguing for the measure, which would be financed through new pay roll taxes, deductions from wage earners' checks and a general fund contribution from the state, Olson said:

"A fundamental change is needed in the method of meeting the costs of medical care and the risks and loss of sickness, especially for wage earners and others of small or moderate income."

Medical organizations have expressed opposition to Olson's proposal as opening the way for "state medicine," while considerable protest has been heard from small business men, complaining against added pay roll taxes. Department of Employment estimates have set the probable annual taxation cost of such a program at $81,000,000.—San Francisco *Examiner,* April 14.

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Impossible Plan

Medicine, Politics Don't Mix

The compulsory health insurance plan now before the state Legislature is bad legislation.

The bill is badly drawn, vague and full of ambiguities. It mixes politics and medicine in a dose that would soon nauseate the recipients—all persons earning $3,000 a year or less.

It imposes thumping new pay roll taxes both on the worker and the employer. It adds these taxes to the pay roll taxes already imposed on worker and employer for social security and unemployment. In some cases the total pay roll taxes would reach 9 per cent, an impossible burden on labor and business, a sure way to multiply unemployment, thereby necessitating more and more taxes, world without end.

The bill creates a politically appointed "governing authority" and a political "medical director." It sets up an advisory board of three union labor representatives, two business representatives, one representative of California medical schools and one doctor. The advisory board is hokum, being without any real powers.

The politicians would run the show. They would run out all but political doctors. There would be no incentive to careful medical practice, but every incentive to political practice. The doctors with the most political pull would get the most business.

Finally, there is an alternative which deserves at least a trial. The doctors themselves are about to offer a low-cost medical and hospital service, under a voluntary insurance plan, to the same group affected by the compulsory insurance bill.

Let us give the doctors a chance to demonstrate their plan before we burden industry—employer and employee alike—with a new load of taxes and tax-eaters.—Editorial, Los Angeles *Examiner,* April 8.

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Compulsory Health Plan Can Wait

As well intentioned as it may be, this is no time to adopt a compulsory health insurance program for California, as strongly advocated by Governor Olson.

In the first place, the administration-backed measure, indorsed by the C. I. O. Labor's Nonpartisan League, calls for financing by a pay roll tax paid by employers and employees, plus state contributions.

There can be little enthusiasm among the workers for another deduction from their pay checks. At this particular time there are too many misgivings over the status of funds collected through an existing assessment. We refer to the recent intimation that money to pay state unemployment benefits will be exhausted by April 30 because the Federal Government has dissipated the pay roll tax collections and Congress has not made the appropriation to replenish them. With the money in this "trust fund" squandered, another pay roll tax levy must be viewed with disapproval.

Aside from the fact that another pay roll tax for health insurance might force many employers to reduce their employee rolls and create more idleness and hardship, the workers look askance at forced deductions from their pay checks. They dislike the precedent it sets. They fear further levies of the kind. Also the idea of compulsory this and that is becoming increasingly repugnant to Californians and Americans, regardless of the good intentions of those who would saddle them with compulsions.

Furthermore, a voluntary plan of health insurance and medical care is being formulated by the California Medical Association. The Association should be afforded an opportunity to show what it can offer before the state goes into the medical business. Medical circles may not be free from politics, but their brand is infinitely to be preferred to control by politicians in Sacramento. If the medicos' voluntary plan fails to receive support, there will be time enough to consider compulsion. And that time should be in a period when the state can better afford costly experiments than in the hard-pressed present.—Stockton *Record,* April 12.

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An Editor's Viewpoint

What could be more suspicious than legislation, ambiguous in its wording and for the politician rather than for the people in its inception?

What could be more unfair to the great majority of citizens than legislation which demands donations from the class of $3,000-and-less-a-year workers, the same group which already contributes, out of its pay checks, for social security and unemployment insurance, money badly needed, in many instances, for the primary necessities of day by day existence?

What could be more staggering than legislation providing for a tax which, when added to the already existing wage slices, would raise the total pay roll tax rate to nine per cent?

What could be more illogical than legislation which, actually necessitating medically trained administration, would be handled instead by diamond stickpin machine-bought politicians; or would, in effect, compel physicians to become politicians?

We answer our own questions when we urge the defeat of the compulsory health insurance bills, Senate Bill No. 1128 and Assembly Bill No. 2172.—Madera *News,* April 6.

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Health Insurance

We think it is high time that St. Helenans think long and carefully about this matter of health insurance, which is certain to occupy the public attention in the immediate future. Some kind of socialized medicine is bound to come. The question before Californians is the what and how of its administration.

Pending before the Legislature are two bills, Senate Bill 1128, and Assembly Bill 2172, which provide for compulsory health insurance, paid for by additional taxation. Get this additional part clearly, for under the compulsory plan as proposed by the authors of the bills, pay roll taxes up to 9 per cent of the state's entire pay roll can be levied to keep it going, together with the other social security undertakings of the state.

Some 3 per cent alone, of the pay roll of the state, will be taken to operate the plan, and there is no assurance that much higher taxes will not be required, once the machine gets going. How can an overburdened business structure take on more deductions?

But the additional taxation feature of the compulsory state idea is not the worst part of the plan. Bad as that is, it cannot compare with the evils of a new machine set up in Sacramento to dictate to every person whose income is under $3,000. A new bureau added to all the other bureaus is just one more prop in the structure of state centralization whose encroachment our town, as well as most others, has steadily fought.

Such a state compulsory setup is bound, it cannot fail, to be ridden with politics. A glance at the headlines any day is proof that it would be a deplorable mistake to trust the lives and health of the great mass of our citizens to the tender mercies of politicians; the administration of state compulsory health insurance would soon reach the same low level as the present handling of other social welfare functions of the state government. And costs would mount steadily under a bureaucracy determined to keep itself in office and add to its powers. It just isn't in the cards for the state to handle such a setup efficiently.

Fortunately for the idea of low cost social medicine, there is another plan, a voluntary plan, but one which previous trials indicate would work. That is the plan now being perfected by the California Medical Association, and which will be introduced to Californians in the very near future. It avoids the evils of compulsory state machine control.

Under the Medical Association's proposal, persons with an income up to $3,000 annually would receive medical and hospital care for $2.50 per month. In other words, an insurance policy, for which you pay $2.50 monthly, entitles you to go to your own doctor, not one the state appoints for you, and receive medical attention, and hospitalization, if need be, at no further cost.

The plan is administered by a corporation set up by the physicians themselves, you pay the monthly premium to the corporation, and receive what medical hospital attention you need, and the corporation in turn pays your doctor and your hospital from the fund created by the premium payments of others. Based on long time surveys of medical costs in the United States, the plan is acclaimed as financially sound. It has worked on a small scale already.

It has the advantage of low cost adminisration by the physicians themselves, no high salaried politicians with the state's taxing power as a weapon can jack the administrative expenses to unworkable heights. Moreover, the figure quoted, $2.50, is for individuals, according to physicians who have been active in devising the plan, a lower rate for families or for groups is entirely possible and probable.

There is no doubt in our mind which is the preferable plan, and which will offer the best solution to the problem of reasonably priced medical and hospital service to the medium income brackets. Some form of group health insurance is bound to come for the great mass of the people who are not wealthy, yet who are not destitute but upon whom illness bears most heavily.

The choice between a forcible state plan with all the attendant evils of governmental administration, and a workable proposal by physicians themselves is obvious. As St. Helenans study the two plans submitted to Californians they will come to the same conclusion, and that is to bend every effort to defeat any state compulsory idea in order that the more practical voluntary physicians' plan may be given the right of way.—St. Helena *Star*, April 7.

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Health Bills Will Be Aired by Committees

Legislative Battle Looms Over Compulsory Insurance Proposals

Sacramento, April 8.—Political maneuvering has started in the legislative battle over compulsory health insurance, with the first open skirmish expected at a joint senate-assembly committee hearing on the evening of April 19.

At that time the assembly committee on unemployment, headed by Assemblyman Fred Reaves of Los Angeles County, will consider A. B. 2172, sponsored by Assemblyman Rosenthal, an Olson administration floor leader, and fifteen other Democrats.

Senator John Phillips of Riverside County, chairman of the upper house committee on social security, pensions and relief, announced today his group will meet with the Reaves committee, by invitation, to listen to the pros and cons of health insurance.

Will Speed Action

Phillips said that if the assembly approves A. B. 2172, the senate committee plans to take it up for action April 27. Otherwise, the senate committee will take up a companion measure, S. B. 1128, by Senators John Shelley of San Francisco and Robert Kenny of Los Angeles.

"A great deal of opposition is developing against these compulsory health insurance proposals," said Senator Phillips, "especially from small business men who claim their operating costs would be increased materially by any such system."

That, judging from reports in other quarters, is the gist of the argument which will mark the anticipated legislative battle.

Olson Backs Move

Governor Culbert L. Olson is definitely committed to the policy of compulsory state health insurance and has told the Legislature so.

Business, or at least a large part of it, apparently is preparing for a determined fight to kill any such legislation. Its major contention is understood to be that employers, already making social security and unemployment insurance contributions, cannot carry any additional pay roll taxes.

Compulsory health insurance, as proposed in the senate and assembly bills set for hearing, would be financed by the contributions of workers and employers, based on pay rolls. . . .

The Shelley-Rosenthal bills call for a plan of compulsory health insurance integrated with the existing state system of unemployment insurance and designed to furnish medical and hospital service to low salaried workers. The bills also provide the same service, on a voluntary basis, for persons within certain age groups who are not eligible under the compulsory program.

Broad Program

The plan is broad enough to include general medical services, hospitalization, specialists' services, nursing, laboratory analyses, x-ray diagnosis, dental surgery and drugs and medicines among its benefits.

Maternity cash benefits are proposed for women wage earners whose annual compensation is not more than $3,000.

Fund contributions would begin, under these two identical bills, next January. Benefit payments would start in January, 1941.

Contributions of employees from their wages and employers from pay rolls are proposed, beginning next January as follows:

On monthly wages under $70—nothing from the workers; 2 per cent from the employer. On wages from $70 to $100—½ per cent from the worker; 1½ per cent from the employer. On wages from $100 to $200—1 per cent from the worker; 1½ per cent from the employer. On wages over $200—1½ per cent from the worker; 1 per cent from the employer.

State contributions would be made after July 1, 1941.

Must Register

Physicians and surgeons wishing to serve state insurance beneficiaries would register under the proposed code for that purpose.

The system would be administered by a bureau of medical service in the state department of employment.

The medical director in charge would be chosen by civil service methods, but would have to be a physician and surgeon with at least ten years of active practice. For the purpose of administration, the state would be divided in medical service districts, each district supervisor having at least five years of experience in medical practice.

A state bureau advisory council would consist of three representatives of labor, two representatives of employers, a physician and a representative of the state's medical schools.

Hit Appropriation

Adversaries of this program expressed elation a few days ago at assembly action for removal of a $200,000 item on health insurance from Governor Olson's budget.

Frankly committed to health insurance legislation, Olson included the $200,000 in his budget to cover initial expenses and open diagnostic laboratory centers.

Critics in the assembly insisted that the appropriation be taken out of the budget and considered later when the actual health insurance measures are taken up. They feared the budget item would commit the Legislature in advance on the controversial health proposition.

Among other pending proposals on various phases of the health insurance question are S. B. 551 and 548, Hollister, and A. B. 2494 and 2501, Garland.—Modesto *Bee and News Herald*, April 8.

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State Health Insurance Program Attacked

Many drug stores will be transformed into soda fountains if the Olson-sponsored compulsory health insurance program becomes law.

That was told the San Francisco Optimist Club yesterday by Dr. Morton R. Gibbons, Jr. Active in civic circles, Doctor Gibbons explained the workings of both the voluntary health insurance plan of the medical association and the state system.

He asserted the Physicians' Health Service would not alter the "physician-patient relationship." The doctor also indicated a higher standard of medical service would be available under the voluntary plan.

The state system would supply drugs to the patient, in contrast to the voluntary plan, and "of necessity" would hurt the druggists, he said.

Doctor Gibbons stated any health program must solve three major problems:

1. The "severe" tragedy when illness strikes a family with an income of less than $2,000.
2. Fixed charges of hospital, laboratory involved in treatment of the patient.
3. Just compensation for reliable physicians, who have spent some $20,000 and eight years in preparing for their profession.

Don B. Wentworth, Optimist president, presided.—San Francisco *Chronicle*, April 13.

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Trimming the Budget

The efforts of the state assembly to trim the Governor's budget resulted in a reduction of some $2,000,000 in the proposed appropriations exclusive of elimination of $500,000 pension increases, but that sum does not make much of a dent in a total of $557,000,000.

The $30,000,000 slash proposed by the minority report of the Ways and Means Committee is the program that needs adoption.

Removal of the $200,000 item for starting compulsory state health insurance, believed to kill this program for the session, is a bigger help than appears on the surface, however, since the sum proposed would merely start an extremely expensive program supported by back-breaking taxation.

Removal of the $73,000,000 relief appropriation from the bill does not itself cut the budget, since relief must then be provided in a separate bill, but it does give opportunity to slice the total and safeguard expenditures so the money will go for relief and not for experiments in state Communism.

A real cut in the budget is urgently necessary because of dropping state revenues. Tax collections are off considerably, including the sales tax receipts, and state indebtednes is soaring to new heights. The state controller says it will be $66,000,000 by July 1 and $85,000,000 by this time next year.

Also, the budget is not the whole story. Appropriation bills in the Legislature outside the budget are said to total $200,000,000. Public pressure must be exercised to prevent their passage.

California is a sound and solvent state, but there is no sense in endangering it by extravagance. The Legislature should do its duty and keep appropriations within proper bounds.—Los Angeles *Times*, April 13.

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State Control of Hospitals

Senate Bill 1874, now under consideration at Sacramento, provides, "The State Department of Public Health is responsible for the control or administration of all public medical care activities . . . in the state."

This is one of those proposals designed to intrude further and further upon local control of local affairs, lodging all public authority and all public jobs in the Sacramento bureaucracies.

Theoretically, by placing every county and other public hospital under Department of Health jurisdiction, standards of practice and treatment would be raised, and, of course, it will be argued that state management would be "more efficient and economical."

We might, or might not, have better county hospitals if they were taken under the wing of the state. But it is extremely doubtful if the cost would be as little as it is now. The bureau would send its own doctors and nurses in. It would, as provided in paragraph E of Section 1 of the bill, "coöperate with counties in promoting expansion of necessary hospitals, clinics and other facilities"—which is throwing the door wide open for grandiose schemes that many little counties could not possibly afford.

The state will do well to place its own house in order before trying to supplant any more county functions and departments.

Government should be as close as possible to the people. Every citizen should be made to feel "The cost of this is coming from my own pocket." Everyone knows the attitude of people towards activities directed from Washington or Sacramento. At such a distance, the average citizen conceives of a governmental agency as a Santa Claus, not as a close neighbor whose every movement is known and understood. And Santa Claus is thought of as having a bottomless sack, filled with gold and blank checks.—Quincy *Feather Inn Bulletin*, April 6.

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Medical Society Opposing Health Program of Olson

Sonoma County Medical Society last night unanimously opposed the Olson administration's compulsory health insurance program and endorsed the California Physicians' Service plan.

Preliminary steps were taken toward calling a joint meeting within a few weeks of professional and business groups in Santa Rosa to explain the reasons for such action, officials explained.

Dr. L. W. Hines, chairman of the society's Public Relations and Legislative Committee, presented his report before action was taken.

The nine contentions given by the society officers for opposing the administration's health insurance program follow:

1. Panel system under which each doctor is given a list of families who must go to him unless they move to another district.
2. No rate of pay per patient as the governing authority sets the fee schedules. The schedules may be changed any time by the authority.
3. Act control is under a governing board comprised of three men from leading labor groups, two representing employers, one from medical schools and one representing panel physicians.
4. Specialty services are not taken care of except in public diagnostic centers by state salaried specialists not conveniently located for all localities.
5. Provides group units of licensed physician (a doctor and staff of low salary men may furnish all kinds of services and be paid special rates).
6. Pay roll deductions probably do not cover cost of adequate medical service in hospitalization as such covers an employee and all dependents.
7. No definition of general practitioner's services. Doctors are paid by the number of names on his files, not by services.
8. Risk from insurance system is placed on the doctor loaded beyond capacity to render sound, qualified medical care.
9. Medical care is placed in the department of employment.

The action of the society was taken against Assembly Bill 2172, Senate Bill 1158 and a measure 551.

The association also went on record opposing the county hospital bill 2499.

The organization voted itself unanimously in accord with the health service plan of the California Medical Association.

D. C. Oakleaf, president, presided at the meeting in the Occidental Hotel.—Santa Rosa *Republican*, April 1.

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Health Agreement Ready for Signing

Final steps for signing of agreements with three nonprofit hospital associations were taken today by officials of the California Physicians' Service.

Actual completion of the agreements, expected within a week, will signalize start of the signing by the physicians' service of groups of patient members.

The hospital groups which already have agreed to coöperate with the physicians' service are the Insurance Association of Approved Hospitals, in San Francisco and Bay area; Intercoast Hospitalization Insurance Association, headquarters at Sacramento, and Associated Hospital Service of Southern California.

Represent 80 Per Cent

They represent 80 per cent of the state's hospitals, with the exception of government institutions and hospitals which do not provide full service, physicians' service officials estimated.

Cost of the rival health plan, Governor Olson's compulsory health insurance program, meanwhile, was estimated at $81,000,000 annually as bills which would launch the state service awaited legislative action.

The estimate was made by the State Department of Employment, which reported $19,677,000 would have to be raised by taxation of employees' salaries, $29,998,500 through additional taxes on employers and $10,000,000 through classification of workers not now affected.—San Francisco *Call-Bulletin*, April 13.

* * *

Hospitals Join Doctors' Group

Three Associations in California Sign Up for Service

San Francisco, April 12 (AP).—The California Physicians' Service, new agency of organized medicine designed to meet the demand for health insurance, today announced it has signed agreements with three large hospital associations.

The announcement said the agreement will make available for the new service about 80 per cent of the hospitals in California, excluding government-owned institutions and those not providing full hospital service.

The associations with which agreements were signed are the Intercoast Hospitalization Insurance Association of Sacramento, the Insurance Association of Approved Hospitals, a group in the Bay area, and the Associated Hospital Service of Southern California, which has the facilities of many institutions in that territory.

The announcement said about 4,700 physicians have signed up to give service. The association previously announced it planned to enlist all licensed physicians in the state, in order that its beneficiary members might have their individual choice of physicians.—Los Angeles *Times*, April 13.

* * *

U. S. P. H. S. Survey Starts; Schools to Be Included

Dr. Francis A. Carmelia, supervising surgeon in charge of the eleven western states for the United States Public Health Service, arrived here on Tuesday morning with three members of his special staff to start the survey of the San Mateo County Department of Public Health.

The survey, he announced, will include the schools. While school nurses are not part of the county department, he explained, the nursing service and physical sanitation of the schools are properly parts of the survey.

Doctor Carmelia met with County Executive Frederick Peterson, members of the board of supervisors, and members of the county board of health prior to taking over the U. S. P. H. S. offices in the service division building back of the court house.—Redwood City *Times Gazette*, April 7.

* * *

Osteopaths Protest Listing by Health Board

Osteopaths and chiropractors protested to the San Francisco Municipal Retiring Board last night against being placed on a panel separate from medical doctors in the city employees' health insurance system.

The Retirement Board took their protests under consideration. Representatives of the two nonmedical groups insisted upon being included in health service plan No. 1, which is now in operation, rather than a proposed special service plan.

The second plan, adopted by the Employees' Health Service Board, would segregate $1 per month from the $2.50 payments of members adhering to it to meet chiropractors' and osteopaths' bills. Fees would be the same as for medical doctors—$2.50 per office visit, $3.50 for home visits and $7.50 for a night visit.

The plan would include the unit rule, under which available funds could be divided among practitioners as far as they would go each month. The fee schedule must be approved by the Retirement Board before it can become effective.

It was brought out that 198 of the 12,000 members of the insurance system had signified a desire to have the services of other than medical doctors. Those electing to be under Plan Two would have the services in case of physicians and surgeons in case of hospitalization.

Attorney Newell J. Hooey, representing chiropractors, and Dr. W. W. Vanderburgh, for the osteopaths, demanded that employees have free choice of physicians, medical or otherwise.

"You cannot mix doctors of medicine and chiropractors," King declared, indicating the same observation went for osteopaths. "We are trying to meet this situation the best way we can."

Miss Murial S. Pettit, Balboa High School teacher, asked that city employees who wish the services of chiropractors and osteopaths be allowed to have them under the existing plan or that such members be allowed to withdraw.—San Francisco *Chronicle,* April 12.

* * *

Clubwomen Boo State Medicine Debate Speaker

Criticism of Doctors by Fresnan Proves Unpopular at Convention

Porterville (Tulare Co.), April 13.—Criticism of opponents of state medicine and particularly physicians opposed to such plans by Rev. J. Covington Coleman of Fresno at the convention of the San Joaquin Valley Federation of Women's Clubs here yesterday drew hisses and boos from the delegates.

Dr. Eliot Sorsky of Fresno, opposing state medicine, had charged the plan had failed in other countries.

Rev. Covington's sharp answer, in which he criticized doctors who "first looked at the pocketbooks of their patients," drew the hisses from a large number of the delegates. . . .

Doctor Sorsky opposed the Governor's plan as described by Mrs. Geballe. He said his arguments were based mainly on his study of socialized medicine in England and forty-five other European countries where different methods are in use. He said he did not believe statistics, however accurate, answered the problem. He asserted that if statistics are to be used, it should also be noted that in European countries, having socialized medicine, the death rate from tuberculosis and other diseases is double that in this country. . . .—Fresno *Bee and Republican,* April 13.

* * *

Health, Bond Bills Headed for Defeat

Action on Compulsory Medical Insurance Postponed by Committee; Four-Hour Hearing Held; Sheriff Murphy, Rowell, Doctor Armstrong Argue in Favor of Measure

Sacramento, April 20.—Two major points in the program of Governor Olson—compulsory health insurance and revenue bonds—today appeared headed for defeat in the Legislature in the wake of committee hearings.

Coming as a surprise move, the assembly's unemployment committee last night postponed action on the compulsory health insurance bill until next Tuesday, after a four-hour hearing in which proponents and opponents aired their views and received applause from crowded galleries.

Most of the arguments advanced by both sides were familiar ones—advocates of the bill contending it would benefit wage earners and medical men alike and would be a tremendous step forward; opponents insisting it smacked of dictatorship and would, by its tax phases, drive pay rolls out of California.

Among those who advocated the bill were Sheriff Dan Murphy of San Francisco, Chester Rowell and Dr. Barbara N. Armstrong. Opposition speakers included Dr. Sanford M. Moose of the California Dental Association, Dr. Samuel Ayres of Los Angeles and George W. Kemper of the Association of Accident and Health Clubs.

Prospects Are Dim

The committee is 5 to 2 in favor of the administration, and postponement of favorable action on the measure came as a surprise. However, this isn't expected to affect the eventual action of the committee. It undoubtedly will recommend the bill, but there is every indication the measure will be killed once it reaches the floor.

The senate committee, which sat in on last night's hearing, is opposed to the plan, and from all indications, won't even report out a companion measure to the senate. . . .—San Francisco *News,* April 20.

* * *

California Health Bill Is Snagged

Liberal Leaders Admit Measure Cannot Pass

Sacramento, April 10.—In spite of radio pleas on the subject by Governor Culbert L. Olson, liberal leaders in the State Capitol admitted today they had virtually abandoned hope of passing any compulsory health insurance act through this session of the Legislature.

What hope they had held since the administration was forced to agree to take a $200,000 health insurance appropriation out of the budget went glimmering with a ruling from Legislative Counsel Fred B. Wood, who said:

"Any bill making an appropriation passed after the budget bill will be ineffective unless it receives a two-thirds vote, regardless of the number of votes the budget bill itself receives."

Take Out Item

Yielding to a vigorous Republican attack, Assemblyman Ben Rosenthal of Los Angeles, chairman of the Ways and Means Committee and author of the budget bill, announced he would delete the $200,000 health insurance item.

This means that the money must be provided in the actual health insurance bill itself—and according to Wood's ruling under the Riley-Stewart 5 per cent limitation in increased expenditures must get a two-thirds vote of the elected membership of both houses.

Even the most ardent administration supporter today admitted small chance that the controversial compulsory health insurance could get a two-thirds vote, and it was known that Rosenthal was being urged by some to go back on his compromise and put up a fight to keep the item in the budget.

Whatever the fate of health insurance, the Legislature reconvened today after the week-end recess and administration leaders in the assembly pressed on with their fight to save the budget from complete emasculation.

Half Billion Budget

Democrats in the lower house went into session today after individual talks from the Governor, who told them all in no uncertain terms that he expected their support in the budget.

As a record-high half billion dollar budget came up as a special order of business again, however, Republican leaders in the assembly claimed to have enlisted enough support to push through many amendments.—Los Angeles *Herald and Express,* April 10.

* * *

Senate Would Adjourn May 5

Assembly, However, Has Deciding Voice on Resolution

Sacramento, April 13 (AP).—The California senate resolved today to adjourn its fifty-third session May 5. The resolution must be adopted by the assembly before it can become effective.

The senate voted, 26 to 8, in favor of the resolution, introduced by Senator Jerrold Seawell of Roseville, Republican whip.

Speaker Paul Peek of the assembly, chairman of the State Democratic Central Committee, said he sees no possibility of such early adjournment.

Most of the thousands of bills introduced into the Legislature are still awaiting action. The only major legislation enacted so far is the $16,000,000 emergency relief appropriation.

Senator J. C. Garrison, Modesto Democrat, suggested adjournment be set for May 25, and Senator Jesse Mayo, Angels Camp, Republican, commented the Legislature would not be through with its work until June 5.—Los Angeles *Times,* April 14.

* * *

Pre-Marriage Tests Spread

Chicago, April 9 (AP).—The Council of State Governments today reported that six states, Indiana, North Carolina, North and South Dakota, West Virginia and Colorado, have approved pre-marital blood test laws in current legislative sessions, bringing to sixteen the total of states with such measures. The Colorado bill, however, still lacks the Governor's signature. The new laws will become effective either this year or next.

Ten other states had previously enacted blood test laws—Connecticut, Illinois, Kentucky, Michigan, New Hampshire, New Jersey, New York, Oregon, Rhode Island and Wisconsin. Ten additional states ask certificates or affidavits from one or both marriage partners that they are free of venereal disease.—Los Angeles *Times,* April 10.

* * *

Los Angeles Medical Center to Seek Socialized Plan

Sacramento, April 25 (AP).—Establishment of a socialized medicine plan will be sought by the Los Angeles Medical Center, which had filed articles of incorporation with the secretary of state today.

Directors are Norman F. Sprague, Dain L. Tasker and Glenn B. Chadwick of Los Angeles.—San Francisco *Call-Bulletin,* April 25, 1939.

LETTERS

Subject: Recent trial and comment thereon by member of Los Angeles Bar.

Department of Professional and Vocational Standards
Board of Medical Examiners
State of California
San Francisco, California
April 25, 1939.

Re: Abos vs. Martyn, D.C.

To the Editor:—We enclose herewith a clipping from the Los Angeles Journal, April 14, 1939, which we think is worthy of reproduction *in full* in California and Western Medicine.

Therein is related that a boy, who subsequently was shown by autopsy to have been suffering from "tuberculosis of the meninges of the brain, or coverings of the brain," was assertedly treated by ———, an advertising chiropractor, who took x-rays and told the parents that the second x-ray showed that the boy's third vertebra was misplaced and that he needed chiropractic adjustments, whereafter Chiropractor ——— assertedly administered several chiropractic adjustments. The boy grew progressively worse and finally died.

The comments made by Harry Graham Balter of the Los Angeles Bar, author of the enclosed article, are very pertinent, particularly his comment on the "apparent inability of society to protect itself from untrained or careless persons who attempt to heal beyond the scope of their training and experience," and his further suggestion that California is unique in its failure to adopt educational safeguards (long urged by you) for adequate training of the nonmedical practitioner in the basic sciences.

The author closes his article with the sentence: "Perhaps the stilled voice of little Leopold Abos will attract powerful social advocacy to right this tragic social danger."

Very truly yours,
C. B. Pinkham, M.D.,
Secretary-Treasurer.

* * *

Case of the Week*

Chiropractors—Malpractice—Wherein a tragic case is presented which should galvanize society into action—but probably won't.

There are probably more doctors per potential patient in this area than anywhere else in the country. Not only do we have the most motley assortment of patients, but as well the choicest collection of practitioners and "doctors" of "off" varieties.

I realize how dangerous it is for one to level criticism at the chiropractor, osteopath, neuropath, and the rest. But when you are presented with a situation such as the Second Appellate District, Division One, dealt with in the case of *Abos* vs. *Martyn* (97 Cal. App. Dec. 26, decided March 27, 1939), how can one help but raise a voice of protest against the apparent inability of society to protect itself from untrained or careless persons who attempt to heal beyond the scope of their training and experience?

In that case the mother of a youngster, named Leopold Abos, noticed that he was "stooping a bit"; the boy said it was painful for him to stand erect since a boy bumped him at school; at about December 1, 1932, the parents took the boy to the defendant, Dr. Clyde A. Martyn, an advertising chiropractor, who took x-rays and told the parents that the second x-ray showed that the boy's third vertebra was misplaced, and that he needed chiropractic adjustments; that Doctor Martyn said, "Don't treat him like a sick person, because he is not sick." Doctor Martyn administered five or six adjustments after which the boy developed fever; that the doctor had the boy put to bed, advising a liquid diet because of his fever, and continued the adjustments regularly until about a week before the boy died, which took place in April, 1933. When the parents became alarmed, Doctor Martyn told them, "No doctor could do more than what I am doing . . . the only thing the boy has is a certain pressure on the spinal cord, on account of the misplaced vertebra, and I am doing the best thing and nothing more could be done for the child."

To add to the tragedy, two or three weeks before the child's death, Doctor Martyn advised the parents that, in his opinion, the vertebra was practically in place and that the child's illness would soon be over. On further questioning at the trial, Doctor Martyn had this to say:

"Q. Did you make any diagnosis of his condition at that time?

"A. In chiropractic, we don't use the term 'diagnosis.' I take it that you want to know if I placed a name on his condition?

"Q. Yes. I want to know if you came to a conclusion?

"A. Yes, I came to a conclusion, but in chiropractic we term it 'analysis,' instead of 'diagnosis.' . . . My analysis was that he had a subluxation of the second cervical vertebra, causing an impingement of the nerves at that point. . . .

"Q. Well, was that an impingement of the nerves or of the cord?

"A. Well, it might have been from both. It was apparent from his condition that there was inflammation of the cord. The inflammation might have been from pressure on the spinal nerves or upon the cord itself.

"Q. So, it was your finding and your conclusion that at all times, from the time of your first treatment to the last, there was some inflammation and congestion of the spinal cord at the region of the cervical vertebra?

"A. Yes."

As a witness for the plaintiff, the autopsy surgeon testified that: "There was no evidence of spinal or other injury. . . . I had been informed that there was some spinal condition existing, and I therefore examined the spine to see if I could find any abnormality, which I did not find." The proper diagnosis, according to the autopsy surgeon, was "tuberculosis of the meninges of the brain, or coverings of the brain."

"Q. What is the medical effect of a chiropractic adjustment upon the cervical vcertebra—particularly the second cervical vertebra, when tuberculosis of the spine exists?

" . . .

"A. It would be detrimental, as rest and quiet would be absolutely indicated in those cases, and that would not pertain to rest and quiet.

"Q. Would it accelerate or increase, in your opinion, the inflammation existing?

" . . .

"A. It would."

Two medical doctors and a chiropractic doctor testified that if the boy's case had been properly diagnosed and had been given proper treatment at the outset he would have recovered.

The verdict of $10,000, based on malpractice, was sustained by the Appellate Court.

The significance of the case lies not in its enunciation of the familiar principles of law which are basic in a malpractice suit (for another recent case discussing these principles see: *Engelking* vs. *Carlson*, 97 C. D. 364, March 24, 1939), but in the dramatic presentation of a dangerous situation.

Must one be accused of being unfair to the nonmedical practitioner if he insists that the healing and treating activities of those not thoroughly trained in medicines and diagnosis must be restricted to administering only to the extent of the basic limitations of their training, and that if such limitation is not adhered to society should enact punitive measures to adequately protect itself?

---

* By Harry Graham Balter of the Los Angeles Bar.

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Potassium as K	2.18
Calcium as Ca	0.098
Iron as Fe	0.048
Magnesium as Mg	0.13
Copper	0.00275
Manganese	Distinct Traces

B VITAMIN TEST

	Average per Gram
Sherman-Chase B_1	45 units
International B_1	25 units
Sherman-Bourquin riboflavin	35 plus units
B complex full growth	2 to 3 units

Mass clinical use indicates one man unit each anti-beriberi, anti-pellagric and extrinsic factor (anemias) per ounce.

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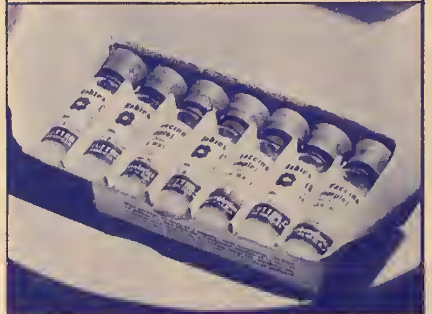

4 Commence treatment at once according to the schedule indicated. Treatment started after the laboratory diagnosis proves positive may be too late.

Institution of rabies treatment after the delay incident to laboratory diagnosis is poor procedure, yet it is sometimes resorted to in order to spare the patient expense which may prove to have been unnecessary. With Cutter's Rabies Vaccine, in seven dose packages, treatment may be started at once. The cost will have been small if the diagnosis proves negative, for there will be few costly doses to throw away. However, if the diagnosis is positive, the physician can have greater confidence of a favorable outcome.

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5 All injections should be given subcutaneously. Many clinicians prefer to make the injections in such areas as the abdominal wall, where the tissues are loose.

6 If the diagnosis proves negative few doses need be wasted. If positive, proper treatment instituted immediately may mean the difference between death and a favorable outcome.

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VOLUME 50
NUMBER 6

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Owned and Published Monthly by the California Medical Association

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"Entered as second-class matter at the post office at San Francisco, under the Act of March 3, 1879." Acceptance for mailing at special rate of postage provided for in Section 1103, Act of October 3, 1917, authorized August 10, 1918.

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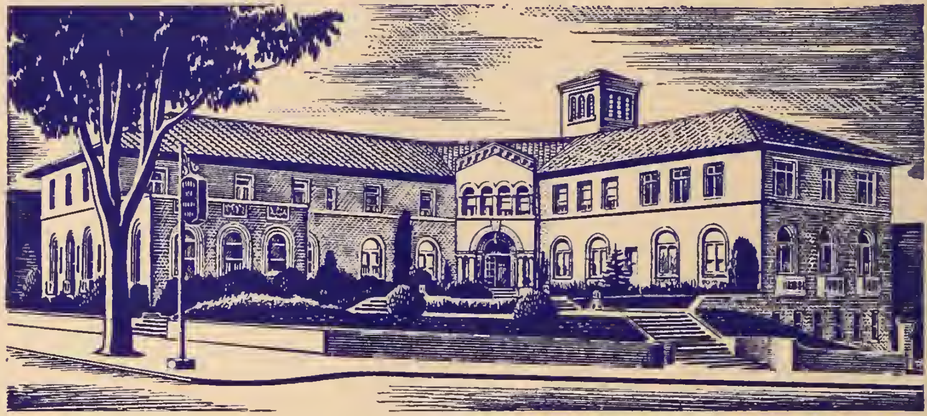

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A survey of pertinent legislation in other states, I believe, will show that California is unique in its failure to adopt these safeguards.

Perhaps, the stilled voice of little Leopold Abos will attract powerful social advocacy to right this tragic social danger.—Los Angeles *Journal,* April 14, 1939.

Subject: Report on an interesting California medical-legal case.

San Francisco, California,
April 7, 1939.

Re: *Tator* vs. *Pacific Employers Insurance Company,* (also known as *Pacific Employers Insurance Company* vs. *Industrial Accident Commission and Kenneth Tator.*)

To the Editor:—You will recall that in the above entitled action we appeared before the California Supreme Court on behalf of Drs. Quigley, Majors and Cary, who rendered professional services to Kenneth Tator, the injured employee. As previously reported to you, the California Supreme Court decided the case in favor of the injured employee and the doctors and against the Workmen's Compensation insurer. Also, as previously reported, the insurance company then appealed to the United States Supreme Court.

We are advised that on March 27, 1939, the United States Supreme Court affirmed the decision of the Supreme Court of California. We have not as yet been able to obtain a copy of the opinion of the United States Supreme Court, but the following item appearing in the San Francisco *Recorder* on March 28 sets forth the substance of the decision and a brief history of the litigation:

"Washington, March 27.—The Supreme Court of the United States, in a decision written by Justice Stone and announced this morning, affirmed the action of the Industrial Accident Commission of the State of California and the decision of the California Supreme Court in the case of *Pacific Employers Insurance Company* vs. the *Commission* and *Kenneth Tator.* The question involved was one of a conflict between the law of Massachusetts and the law of California, and the Supreme Court upheld the application of the California law.

* * *

"In 1935, Kenneth Tator, a chemical engineer, was sent by his employer, the Dewey & Alma Chemical Company, from its plant in Massachusetts to its plant in Oakland. On October 17, 1935, Tator received a serious injury to his hand while working at the Oakland plant. He filed an application with the Industrial Accident Commission seeking benefits under the California Compensation Act. The Pacific Employers Insurance Company carried the chemical company's compensation insurance in California, and the Hartford Accident & Indemnity Company carried such insurance in Massachusetts. The Pacific Employers contended the liability was that of the Hartford on this ground.

"The Massachusetts Compensation Act provides that one employed in Massachusetts elects to be governed by the Massachusetts Compensation Act for injuries no matter where sustained. The California Compensation Act provides that it governs over all injuries sustained in the State of California regardless of where the contract of employment is entered into.

"The Industrial Accident Commission held the Pacific Employers liable, and that insurance company appealed by writ of review to the California Supreme Court.

"Briefs were filed and the matter argued by Attorneys G. S. Keith and Frank J. Creede in behalf of Tator, and Everett A. Corten in behalf of the Industrial Accident Commission. An amicus curiae brief was filed by Hartley F. Peart and Howard Hassard in behalf of numerous California doctors who wished the action of the Industrial Accident Commission upheld on the ground that California doctors who treat injured men in this state should be able to seek payment of their bills here rather than go to some other jurisdiction.

"The California Supreme Court upheld the award in favor of Tator. The Pacific Employers Insurance Company thereupon obtained a writ of review in the United States Supreme Court. William H. Mullen argued the matter in Washington on behalf of Pacific Employers. Everett A. Corten and Frank J. Creede likewise argued the matter before the United States Supreme Court.

"The Supreme Court has now held that the California law is applicable and the liability is that of the Pacific Employers Insurance Company rather than the Hartford Accident & Indemnity Company."

The decision of the United States Supreme Court now settles once and for all the right of an employee to secure compensation in the state in which he is injured. It further settles the right of doctors who render services to such injured employees to be paid in the state in which they rendered services. This is of great importance to all physicians doing industrial work, because otherwise in many cases it would be necessary to proceed for compensation in distant places.

111 Sutter Street. Very truly yours,
Hartley F. Peart.

Subject: Enforcement of Medical Practice Act.

San Francisco, California,
April 8, 1939.

To the Editor:—We enclose herewith a report by Special Agent Williams dated April 7, 1939, which clearly sets forth the difficulties in enforcement of the Business and Professions Code relating to the practice of medicine.

We thought the information contained in the enclosed letter would be most illuminating for readers of California and Western Medicine.

Very truly yours,
C. B. Pinkham, M. D.,
Secretary-Treasurer.

* * *

(copy)

San Francisco, California,
April 7, 1939.

C. B. Pinkham, M. D.
Board of Medical Examiners
214 - 515 Van Ness Avenue
San Francisco, California.

Re: Henry Wong, Chinese Herbalist.

Dear Doctor Pinkham:

Supplementing my report of February 14, 1939, re: the above Chinese herbalist, whom I arrested in Salinas on March 24, 1939, on two counts of violating Section 2141 of the Business and Professions Code, I am giving you herewith the final disposition of the case.

On March 29, 1939, the above case went to trial before a jury and Harry J. King, Justice of the Peace, Salinas.

Following two days of testimony, most of which was produced on behalf of the prosecution the case went to the jury for deliberation at 5 p. m. on March 30, 1939, and after several hours' deliberation a verdict of not guilty was returned at 9:30 p. m. that day.

Four witnesses testified for the prosecution to the fact that Wong had represented himself as being a doctor; had examined and diagnosed their condition; prescribed and treated for same. Evidence was also produced and corroborated that Wong had used certain anatomy charts showing the cross section of the human organs in his diagnoses and had pointed to the ureters shown on one of said charts and called them prostate glands, telling the patient that they (prostate glands) were the cause of patient's condition.

Mr. ——— of Soledad, California, testified that several months ago he had gone to the defendant. Wong examined him and told him he had gonorrhea. He further testified that Wong treated him over a period of several weeks for which Wong charged $30 a week and that he paid Wong a total of $315 for said treatment.

B——— further testified that, prior to going to Wong, he had been examined by Doctor Chase of Soledad, and Doctor Chase had found no trace of a gonorrhea condition. After going to Wong for many weeks, he spent four days in the University of California Hospital in San Francisco, where urology specialists made thorough examinations and were unable to find any trace of gonorrhea, but that he had a bladder condition which was entirely divorced from a social disease.

B——— did not state as to why he happened to go to Wong in the first place, but did state that his reason for spending so much money with Wong was due to the latter's convincing argument.

The defendant then took the witness stand on his own behalf and virtually admitted everything of which he had been accused. The only part of the evidence against him that he denied was the part that showed he had felt the patient's pulse. He claimed to only shake hands. However, he admitted treating ——— for gonorrhea, prescribing and treating the other patient, who had testified and admitted that he had told the undersigned that his ureters were prostate glands which were infected and causing a serious condition.

At the end of Mr. Wong's testimony, the defense rested its case.

In addition to the testimony of four witnesses, all of which was corroborated by other witnesses and by stipulation, we had a large supply of evidence, which is included in the memorandum of evidence and testimony, produced at the trial, which is attached herewith and is too lengthy to include in another report.

Subsequent to arguments by counsel and instructions given by the judge, the case went to the jury and it was remarked by both the judge and the defense attorney that the jury would return a verdict of guilty. It was further stated by the judge that if they did not find the defendant guilty, it would not be because of lack of evidence, but because "they don't want to." The defense attorney said that the best he could hope for was a disagreement. However, I think we were all quite surprised at 9:30 that evening when the jury brought a verdict of not guilty.

Very truly yours,
Joseph W. Williams,
Assistant Special Agent.

Subject: Pacific Science Congress.

(copy)

National Research Council

Washington, D. C.,
April 3, 1939.

To the Editor:—It may be recalled that since 1920 there has been held in several countries of the Pacific region a series of Pacific Science Congresses of which the fifth was held in 1933 at Victoria and Vancouver, British Columbia, under the auspices of the National Research Council of Canada.

It has recently been determined to hold the sixth congress of this series in the United States of America in 1939, under the general auspices of the National Research Council, and I am happy, on behalf of the Council, to extend to the California Medical Association a cordial invitation to participate in the Congress by the appointment of a number of its members as representatives on this occasion. We shall be appreciative if you will let the Research Council know, when convenient, who these representatives are to be.

The Congress will take place in San Francisco and vicinity between the dates July 24 and August 12, 1939. Certain sessions of the Congress will be held in Pacific House of the Golden Gate International Exposition through the courtesy of the Exposition authorities. Other sessions of the Congress will be held on the grounds of Stanford University, near Palo Alto, and of the University of California at Berkeley, by courtesy of the authorities of these institutions.

Information concerning present plans for the Congress will be provided in advance announcements to be issued by the Council or by the Council's Committee on the Sixth Pacific Science Congress, of which Dean Charles B. Lipman of the University of California at Berkeley is the chairman.

We hope that word concerning the Congress can be given to the membership of the California Medical Association as widely as opportunity may afford, and that the interests of the Association in scientific problems of the Pacific region can be fully represented at the Congress both in the number of members who may attend and in contributions to the program.

2101 Constitution Avenue.

Sincerely yours,
Ross G. Harrison, *Chairman.*

Subject: Use of deceased licentiate's name.

San Francisco, California.
March 28, 1939.

To the Editor:—We thought perhaps the readers of the Journal might be interested in the enclosed opinion (NS1550), dated San Francisco, March 23, 1939, rendered by the Attorney-General, advising that the use of the name of a deceased licentiate is illegal.

Very truly yours,
C. B. Pinkham, M. D.,
Secretary-Treasurer.

* * *

(copy)

State of California
Legal Department

San Francisco, March 23, 1939.

Charles B. Pinkham, M. D.
Secreary-Treasurer
Board of Medical Examiners
San Francisco, California.

Dear Sir:

I have your communication asking whether, in the opinion of this office, a physician may legally use the name of a deceased physician and surgeon.

In reply, this office is of the view no person may use a name other than his own in connection with the announcement of or actual practice of medicine or surgery.

Section 2393 of the Business and Professions Code reads as follows and covers the question asked by you:

> The use of any fictitious name, or any name other than his own, by the holder of any certificate in any sign or advertisement in connection with his practice or in any advertisement or announcement of his practice constitutes unprofessional conduct within the meaning of this chapter.

In the case entitled *People* vs. *Wilkes*, 163, N. Y. S. 659, a licensed physician advertised under the designation "Russian Medical Help. First Consultation Free." The New York law prohibited persons from practicing or advertising to practice under a name other than their own, in much the same language as does our statute.

The Court indicated that the purpose of the statute was to "effect definite identification of the practitioner, so as to prevent injury by fixing responsibility, which may be accomplished by the restraining influence of publicity, as well as by the ready means furnished by subjecting an offender to punitive discipline," and held the law violated.

If the use of such a name in an advertisement in connection with the practice of medicine is improper, so certainly would be the use of the name of a deceased licentiate.

Very truly yours,
Earl Warren, *Attorney-General.*
By Lionel Browne (Signed), *Deputy.*

SPECIAL ARTICLES

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CALIFORNIA HEALTH RECORDS BROKEN IN 1938

Death rates for typhoid fever, tuberculosis and diphtheria were reduced measurably in 1938 and it would appear that these rates may be approaching an irreducible minimum. The control of typhoid fever constitutes a typical example of the results that may be achieved through the application of standard practical measures that make use of the principles of engineering, sanitation and preventive medicine. In 1906, 32 out of every 100,000 people living in California died of typhoid fever, and in 1938 the death rate was 0.83 per 100,000 population. While the most outstanding reductions in deaths from these diseases occurred prior to 1920, there have been marked decreases since that year. In 1920 the typhoid case rates was 32.8 and the death rate was 4.9, as compared with a case rate of 7.1 in 1938 and a death rate of 0.83.

Let it be remembered that California is dependent largely upon surface streams for public water supplies and surface streams are much more liable of pollution than underground sources. Great vigilance must be observed, therefore, in the protection of public water supplies taken from surface sources. The fact that California has achieved a typhoid rate, under the circumstances, that is comparable to similar rates in states where sources are found mostly in underground supplies, may be considered a matter of pride to state and local health organizations.

Public water supplies are adequately protected and outbreaks due to contaminated milk supplies seldom occur at this time. The custom of irrigating vegetables with water from contaminated sources has been eliminated. However, Mexicans and Orientals commonly drink water from open ditches and other polluted sources. Local health officers occasionally find typhoid carriers and measures are instituted promptly to prevent occurrence of cases of disease through contact with carriers. Group cases occur occasionally but not often. Most cases are sporadic.

The large body of efficient local health officers scattered throughout the state have been trained in their duties and are alert in their activities to prevent the occurrence of cases of this disease. Public water supplies are treated so as to prevent the occurrence of illness through any contingency of contamination that might occur. Safeguards are thrown up everywhere and with the present machinery running efficiently, it is unlikely that an epidemic of typhoid fever will occur anywhere except in the extreme rural districts.

The State Department of Public Health has led these activities through its sanitary engineering, sanitary inspection, and epidemiological functions. The Bureau of Sanitary Engineering, organized in 1915, approves of all plans for disposal of public sewage and for the provision of public water supplies. The Bureau of Sanitary Inspection directs many of its activities toward the protection of domestic water supplies and the abatement of faulty practices in domestic sewage disposal. The Bureau of Epidemiology assists local health officers in diagnosis, epidemiological investigations including detection of carriers and the control of cases of this disease.

Under state leadership, local health departments throughout the state have been instrumental in bringing about the conquest of this disease and they may well be proud of their achievements in practically ridding California of a preventable disease that occurred commonly twenty-five years ago. In the annals of the state's health history, no record is more outstanding than that of typhoid fever control.

DIPHTHERIA

The record in diphtheria control is almost as outstanding as that of typhoid fever control. In 1920 the state's diphtheria case rate was 164.1 per 100,000 population and the death rate was 12.8. In 1938 the diphtheria case rate was 24.3 and the death rate was 1.4. The decreases in the incidence and mortality from this disease have been steady throughout almost two decades, and the results achieved have come through the use of immunization procedures and extension of activities in public health education. More difficulties are encountered, naturally, in the control of a disease that is dependent upon the application of preventive measures upon the individual rather than upon the environment. Typhoid fever has been controlled largely through the correction of environmental conditions while diphtheria has been controlled through education and the application of immunization upon individuals.

In spite of the difficulties encountered, local health officers have been able to apply preventive measures, in their respective territories. The death rate of 1.4 per hundred thousand for this disease in 1938 indicates the efficiency of the program for the control of this disease and the thoroughness with which it is conducted. It was not so many years ago that diphtheria was the greatest scourge of childhood.

INFANT MORTALITY

Since 1920 the California infant mortality rate has been almost cut in half. In 1920 the rate was 75.0 per 1,000 live births and in 1938 the rate was 43.8. The Bureau of Child Hygiene of the California State Department of Public Health has been active in stimulating the adoption of routine procedures throughout California that would provide safeguards against needless deaths of infants. In some communities of the state, where social and racial conditions are particularly favorable, infant mortality rates have been achieved that compare favorably with those of any communities throughout the world. The large Mexican population of California, however, precludes the possibility of reducing the state's infant mortality rate greatly.

Bad sanitary and social conditions, as well as congenital disease, makes the achievement of successful campaigns in the reduction of Mexican infant mortality extremely difficult. Approximately 15 per cent of all births in California are among Mexicans and approximately one-third of infant deaths that occur in California are in Mexican babies. In the 1938 tabulation, excluding the Mexican infant deaths, the rate of infant mortality for all races in California was a little more than 30 per 1,000 live births. In consideration of the fact that, for biological reasons, a certain proportion of infant deaths cannot be prevented, it would seem that the state infant mortality rate is fast approaching a point of stabilization, if not an irreducible minimum. Stimulated by

Social Security funds, activities in local communities for the health protection of mothers and children have increased greatly during the past year. It must be remembered, however, that the infant mortality rate, to a large extent, is affected by conditions that are not under human control and that the annual general trend of the rate is similar throughout most of the country. The activities that are directed toward the saving of infant lives are productive of results, however, in spite of the fact that congenital defects play an important part in the production of high infant mortality rates.

SMALLPOX

In 1936 there were but 2.2 cases of smallpox per 100,000 population reported in California, while in 1920 there were 127.0 cases per 100,000 population. Since the method of prevention in the control of this disease is well known and has been practiced for decades, it is clear that the control of the disease depends entirely upon the thoroughness with which vaccination is applied.

In those communities where 50 per cent of the population is vaccinated against smallpox, the disease never becomes epidemic. The remarkable reductions in the prevalence of smallpox throughout California indicate the thoroughness with which public health measures are enforced by the health officers of California. In those counties where full-time health service is established, the general population has been offered vaccination freely.

In 1937 and 1938 the smallpox case rate has risen to 10.7 and 19.0 per 100,000 population, respectively. These increases are not due to any laxity upon the part of public health authorities in California but rather to the importation of cases into the state by migratory agricultural laborers and spread of the disease in local communities. Contacts with cases in the families of migrants have contracted the disease and the increased prevalence is due to this fact. Although many cases have been brought into the state during the past few years, the State Department of Health, assisted by local health officers, has kept smallpox under control and no serious outbreaks have occurred among migratory agricultural laborers or contacts with cases in migrants. Had the resident population of California not been vaccinated against smallpox, it is certain that through contact with these itinerant cases widespread epidemics of this disease might have occurred.

California's record in the control of typhoid, smallpox, tuberculosis, diphtheria and infant mortality is outstanding and compares favorably with similar results that have been achieved in states that have made far greater expenditures in the protection of their public health. The achievement of these records has been dependent upon the efficiency of organizations and individual workers rather than upon the expenditures of vast sums of money.

The California State Department of Public Health takes justifiable pride in the activities of local health officers, public health nurses, and members of its own staff in the prevention of the diseases and savings in human lives that have come about through these coördinated activities.

CALIFORNIA RATES

	Typhoid		Smallpox	T. B.		Diphtheria		Infant
	Case	Death	Case	Case	Death	Case	Death	Mortality
1920....	32.8	4.9	127.0	250.0	152.6	164.6	12.8	75.0
1930....	13.0	1.7	54.8	197.0	98.2	53.6	3.4	58.6
1935....	8.5	1.2	4.9	131.3	72.0	33.7	2.1	49.5
1936....	9.3	1.1	2.2	125.9	72.2	31.4	2.0	53.0
1937....	7.7	0.87	10.7	124.3	67.8	23.5	1.6	53.7
1938....	7.1	0.83	19.0	115.2	60.5	24.3	1.4	43.8

WAGNER NATIONAL HEALTH BILL: AN IMPRESSIVE MEASURE*

The Medical Society of the State of New York evidently does not think any too highly of Senator Wagner or of his so-called National Health Bill. Its *Journal of Medicine* says that, "with all due respect to the senior Senator from New York," it would characterize the bill as extremely amateurish, "did we not suspect that this veteran political strategist has purposely drawn it so vaguely that its passage through Congress would encounter the least amount of oppositional friction in its passage toward enactment." In addition to that, the publication thus speaks of the bill:

> It is wholly impractical, it is almost unworkable, it is certainly extremely vague, and absolutely unsuitable from our standpoint. If enacted into law, it will bring the medical profession into such difficulties that it will take decades to extricate ourselves from them. Particularly will it be difficult to evade the bureaucratic interpretations which must be made, perforce, because the bill is full of uncertain terms, and contains too many unprecedented tentative permissive clauses.

The journal's chief complaint against the measure is that the bill does not even meet the major proposals of the National Health Conference; that it makes no provision for the establishment of adequate medical standards; that it gives too much authority to state health officers; that it places the control of medical practice under the supervision of lay heads of political bureaus; that although there is "some vaguely outlined provision calling for the development and education of medical career officials," this may mean the "experimental set-up of an educational system" which ultimately will lead to "straight state medicine." It suggests that in any scheme for the coördination of local community needs care should be taken to keep it out of the hands of a "purely political group" that will never lose sight of the effect its decisions may have upon voters.

Whatever else may be said about the stand thus taken, the *Journal of Medicine* is certainly on firm ground when it argues that legislation of such importance should be precise in its terms. Imprecision in terms is, however, the hot-bed in which bureaucracy most flourishes. No better evidence of that can be found than in the story of another piece of legislation associated with Senator Wagner's name—the National Labor Relations Act.—New York *Sun,* April 4.

WAGNER HEALTH MEASURE CALLED HUGE POLITICAL BRIBE

New York, March 31 (AP).—Frank Gannett, Rochester, New York, publisher and chairman of the National Committee to Uphold Constitutional Government, today said the proposed Wagner national health bill was "in effect a huge bribe to install politically controlled medical service."

Gannett said the act, introduced in Congress recently by Senator Robert F. Wagner (D.), New York, would "have even more damaging results than his (Wagner's) NRA and National Labor Relations Act which have promoted strife in industry and delayed recovery."

The publisher said in a statement that the measure would "put the Federal Government far into the field of medical care from which it will never retreat."

DISEASE OF POLITICS

"Using federal and state funds," he said, "it will set up government hospitals and a vast system of tax-supported medical care that may, in the end, undermine and drive out of existence all private and church hospitals and the private practice of medicine.

"So humanitarian and praiseworthy are the objectives (of the act) that one must be brutally frank to point out that the diagnosis behind them is careless and inaccurate, that the prescription is wasteful and unscientific, and that the 'cure,' instead of achieving the desired result, would infect the practice of medicine with an almost fatal disease.

"That disease is politics.

SEEN AS HUGE BRIBE

"On the face of it, the Wagner Bill does not provide for compulsory health insurance. With almost insidious deft-ness it leaves such a matter to discretion of the states. They must decide whether to adopt insurance or set up a system of tax-supported state medicine; and if they fail to adopt a plan acceptable to the Federal Government, they must do without liberal tax money allotments from the Federal Government.

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* Concerning Wagner Bill, see page 368.

"Thus in effect, the Wagner Bill is a huge bribe to install politically controlled medical service."—Los Angeles *Times*, April 1, 1939.

UNITED STATES DEBT FORTY BILLIONS AS "CEILING" NEAR

Washington, April 1 (AP).—The treasury's debt passed the 40,000 million dollars mark today, coming within 5,000 million dollars of the statutory limit.

Although the administration has considered increasing the legal debt ceiling to 50,000 million dollars, it has decided against asking Congress to make the change this year.

The debt, largest in the nation's history, now is equivalent to approximately $305 per person. A year ago, the $37,556,302,000 debt equaled $289.17 per capita.

Other milestones were the prewar low of $1,282,044,346, equal to $12.36; the high of World War financing, $25,478,592,113, equal to $250.18; the postwar low of $16,026,087,087, equal to $129.66, and the pre-Roosevelt point of $20,937,350,964 on March 3, 1933.

The debt has increased 2,850 million dollars in the last year alone.

Today's debt is a few millions over 40,000 million dollars because of the customary first-of-the-month borrowing of 50 million dollars from the old age reserve fund. The exact figure for today will not be available for a few days, however.

The treasury debt does not include the 5,400 million dollar obligations of governmental corporations which are guaranteed by the treasury but are excluded from the treasury indebtedness because of the assumption that the corporations will repay them. The guaranteed debts include: Home Owners Loan Corporation, 2,900 millions; Reconstruction Finance Corporation, 810 millions; Federal Farm Mortgage Corporation, 1,385 millions; Commodity Credit Corporation, 205 millions, and United States Housing Authority, 100 millions.

AVERAGE U. S. INCOME TOLD

Earnings of Typical American Family in 1938 Put at $2,116

New York, April 9 (AP).—The average effective buying income of the average American family in 1938 was $2,116, the magazine *Sales Management* said today in its tenth annual survey of buying power.

The average individual American had approximately $492 to spend last year, it added.

DECLINE ESTIMATED

The nation's estimated total income for 1938, at $63,274,609,000, was about 12 per cent less than in 1937, but half again above the acute 1932 depression low of $41,000,000,000, the publication said.

New York was first among states with a family average of $3,069; Nevada was second with $2,777, and California third with $2,733. Other leading states were Massachusetts $2,673, Rhode Island $2,601, New Jersey $2,587, Wyoming $2,584, Connecticut $2,560, Minnesota $2,440, Delaware $2,369, Maryland $2,362, and Washington $2,339.

DES MOINES LEADS

Of major cities, Des Moines was first with a per-family effective spending income of $3,778, followed by Washington, D. C., $3,767, Minneapolis $3,700, New York City $3,609 and Dallas $3,584. Ten next principal cities of the first 15, in order, were Houston, Davenport, St. Paul, St. Louis, Ft. Worth, Kansas City, Miami, Tulsa, San Francisco and Boston.

Thirty major cities in all exceeded the $3,000 mark for per family effective spending incomes.

SIGNIFICANT TO SOUTH

The average white family in the United States last year had $2,252, which was only $136 above the all-family average for the country, a fact of especial interest in southern states, the magazine reported.

In South Carolina, for example, where the average effective buying power of all families was estimated at $1,176, the average buying power of the white family stands at $1,590.

MORTALITY RATE AT ALL-TIME LOW

Observing the thirtieth anniversary of its health program started in 1909 for the benefit of millions of industrial policyholders, the Metropolitan Life today released figures to show some of the results accomplished during those three decades. The following are the highlights of the report:

Death rate among the policyholders dropped from 12.5 per 1,000 in 1911 to 7.7 per 1,000 in 1938, the lowest in their history.

The average length of life of the policyholders is fourteen years longer than it was thirty years ago, having advanced from 47 years to about 61 years.

Some phenomenal reductions in mortality from individual diseases that took place during this period are indicated by declines in their death rates per 100,000 policyholders.

Tuberculosis, from 224.6 to 46.9; influenza and pneumonia, from 131.1 to 58; typhoid fever, from 22.8 to .9; Bright's disease, from 95 to 53.2; accidents, from 77.4 to 48.3.—San Francisco *Call-Bulletin*, April 13.

SOCIAL SECURITY SURVEY REVEALS AVERAGE WAGE

Washington, April 9 (Exclusive).—Analysis of earnings made public today by the Social Security Board disclosed the average American wage for workers coming under the board's old-age security act as $890 annually. John J. Corson, director of old-age insurance, pointed out that wages in excess of $3,000 a year from one employer were not counted under the tabulation.

In a breakdown by states, California with $912, has the twelfth highest average wages per employee of any state.

CALIFORNIA STATISTICS

In California $1,860,464 employees covered by the act received $1,695,163,619 in reportable wages during 1937, the report showed.

The analysis showed that employees receiving less than $3,000 a year constitute 97 per cent of the total number of American earners covered in the survey and their earnings about 90 per cent of the total volume of wages.

Younger workers were found to be more numerous than those in the older-age groups, but the average wage earned by older workers was higher.

ELDER EARN MORE

"Fully 60 per cent of the 30,150,000 employees were between the ages of 20 and 40," the report stated. "Those between the ages of 40 and 60 amounted to only 20 per cent of the total, or less than half the younger group. But the average wage of the older group was $1,185, more than a third greater than the average wage of $860 received by the younger workers."

The average taxable wage of approximately 700,000 employees between the ages of 60 and 65 was $1,086, or almost double the average for some 5,700,000 employees between the ages of 20 and 25, the study showed. The age group showing the highest average wage—$1,204—was that from 45 to 50 years of age—constituting 8 per cent of the total number of employees studied.—Los Angeles *Times,* April 10.

CANCER CONTROL MONTH

With this as its slogan and in accordance with President Roosevelt's proclamation designating April as "Cancer Control Month" more than 600 women this week will take the field under the direction of Mrs. William H. Daniel, Southern California Commander for the Women's Field Army Division of the American Society for the Control of Cancer. The object of the drive will be to teach men and women that cancer is curable in its early stages and to urge preventive measures to reduce the annual cancer mortality of 150,000 in the United States.

More than 100 nurses under the supervision of Mrs. Cullen Ward Irish, lieutenant commander of the Women's Field Army, will be stationed in the drug stores throughout the southland to better acquaint the public with the early symptoms of cancer.

Members of the Women's Field Army led by Mrs. Daniel, through local committees and speakers will stress the fact that 70,000 people might have been saved from death by cancer last year if they had heeded certain early signs of cancer and had early treatment. These early cancer signs are enumerated as: any persistent lump or thickening especially in the breast; any irregular bleeding or discharge from any body openings; any sore that does not heal, particularly about the tongue, mouth or lips; persistent indigestion often accompanied by loss of weight; sudden changes in the form or rate of growth of a mole or wart.

As a part of the campaign to check the spread of cancer and to create a fund with which to fight the disease donations will be asked of the public. Seventy per cent of all monies received will be spent in the state wherein it was raised under the approval of the American Society of the Control of Cancer.

Members of the Southern California executive committee are Clarence G. Toland, past president of the State Medical Association, chairman; and C. R. Robinson, vice-president of the Bank of America, as treasurer; Dr. Hiram C. Weaver, director of the American Society for the Control of Cancer; Dr. William H. Daniel, president of the Los Angeles County Medical Association; Dr. E. Eric Larson, president of the Los Angeles Surgery Society; Dr. Alvin G. Foord, chief of Pathology at the Huntington Memorial Hospital in Pasadena; Dr. Henry J. Ullmann, chief of Radiology Department and Cancer Research, Cottage Hospital, Santa Barbara; Dr. Albert C. Sellery, former chief of staff at the Seaside Hospital, Long Beach; Dr. Orville N. Meland, and Dr. Hall G. Holder of San Diego.—Victorville *News-Herald,* April 7.

PREFERRED PROOFS OF AGE

There has never before been such a demand for proof of age as at the present time. The Veterans' Administration, Social Security Board, Railroad Retirement Board, Civil Service Commission and Department of State, all government agencies, have outlined their preferences in the types of evidence necessary to prove age in their respective departments. The United States Bureau of the Census, with the Social Security Board, has prepared a summary in three preference groups which is reproduced here for the benefit of the large numbers of individuals who demand this information from local registrars of vital statistics. It should be noted that in every department the certified copy of the birth record is given first preference. The birth certificate has become, without doubt, the most useful legal document of the average American citizen.

Demands for proof of age have shown a marked increase during the past few years, largely as a result of governmental requirements. This is especially true for the filing of claims for pensions and other benefits provided under social security legislation.

For proof of age, the most acceptable evidence is a certified copy of a birth certificate filed at the time of birth. A certificate placed on file at a later date, especially if filed at a time when there is a specific purpose for doing so, has comparatively little value as proof of the facts stated thereon. In such cases, other information must be presented. Original census records afford evidence acceptable to courts and other agencies but should be used only as a last resort.

The following summary divides the evidence of proof of age into three preference groups. Group 1, Types Given First Preference, includes only records made at the time of birth or very shortly thereafter. Group 2, Types Given Second Preference, includes records which are usually considered acceptable without corroboration, although evidence from two or more sources may be required if circumstances warrant. Group 3, Types Given Third Preference, includes records which usually require corroboration from two or more sources.

Department of State

(Passport Regulation)

Types Given First Preference

Certified copy of public record of birth.

Certified copy of church record of baptism, provided that these records were created within a short time after date of birth.

Types Given Second Preference

Affidavit of parent, physician, nurse, or midwife who attended birth.

Types Given Third Preference

Affidavit of a reputable person having sufficient knowledge to be able to testify as to the place and date of birth, incorporating briefly therein how and through what source the knowledge was acquired.

Social Security Board

Bureau of Old-Age Insurance

Types Given First Preference

Certified copy of public record of birth, or certified statement of date shown on such public record.

Certified copy of church record of infant baptism.

Sworn statement of two other persons having knowledge thereof.

Types Given Second Preference

Bible or family records.

Certified copies of excerpts from business, fraternal, school, governmental, or other similar records.

Data supplied by government agencies, as authorized.

Other documents (including insurance records and passports), or evidence deemed by board to be of probatory value acceptable to the board.

Types Given Third Preference

No type given.

Bureau of Public Assistance

Types Given First Preference

Accepted without investigation:

Certified copy of public record of birth.

Transcript of birth record.

Types Given Second Preference

Accepted without investigation, unless cororboration seems desirable:

Baptismal and parish records.

U. S. Census records.

Marriage records of applicant or his children.

Records of school, homestead, naturalization, voting registration, and court. Military records.

Immigration papers.

Passports. Poll tax exemption certificates.

Types Given Third Preference

Corroborated from two or more sources usually required:

Family register, town and county histories; records of hospital, midwife, employment, trade union, fraternal organization, tombstone, slave sale, and vaccination.

Bible records; Who's Who.

Fishing, hunting, and drivers' licenses; legal papers; insurance policies.

Railroad Retirement Board

Types Given First Preference

Certified copy of public or church record of birth.
Records of school, insurance, trade union, marriage, naturalization, vaccination, Bible, and family. Passports.
Employers' records.
Fraternal records.
Military records.
Immigration papers.

Types Given Second Preference

Last resort items:

Drivers' permits.
Voting registration records.
Game licenses.
Newspaper and magazine clippings.
Poll tax exemption certificates.
Affidavits.
Other documents considered equally or more reliable.

Types Given Third Preference

No type given.

Civil Service Commission

Types Given First Preference

Certified copy of public record of birth.
Certified copy of baptismal or other church record.
(Above records must be based on information filed at time of birth or shortly thereafter.)

Types Given Second Preference

Original or certified copy of family record was made at time of birth or shortly thereafter. This must be accompanied by affidavit of Notary Public.
Statement from attending physician based upon his professional record.
U. S. Census records showing earliest available record of age.

Types Given Third Preference

School records.
Naturalization papers.
Immigration records.
Passports.
Insurance policies.
Affidavits of parents, relatives, or other persons.
Other documents.
(Two or more of above forms of evidence are desirable.)

Veterans Administration

Types Given First Preference

Certified copy of public record of birth.
Certified copy of church record of baptism.

Types Given Second Preference

Affidavit of attending physician.
Affidavit of midwife in attendance at birth.
Affidavits of two or more persons (preferably disinterested).

Types Given Third Preference

Bible or other family record of birth, certified as to date when made.
U. S. Census records.

American Medical Association Annual Reports Published.—According to the By-Laws of the American Medical Association, all reports of officers must be published one month in advance of the annual meeting. In *The Journal of the American Medical Association* for April 8 are published these reports. They give in retrospect the outstanding activities of the Association for the past year. The following is a list of some of the accomplishments named in these reports:

In 1934 there were 98,041 members and 60,714 Fellows. In 1938 these totals had grown to 109,435 and 68,478 respectively and on March 1, 1939, the official membership totaled 112,210 physicians and 69,468 Fellows.

Commenting on these figures in his report, Olin West, M. D., Secretary of the Association, says: "The figures here presented would seem to refute definitely statements emanating from various sources during these five years designed to indicate that there has been great disaffection in the ranks of the physicians of the United States and great diminution in the support of the profession generally for the established policies of the American Medical Association."

Total income in 1938 was larger than in 1937, but the increase in total expenditures was considerably larger than the increase in income, the Board of Trustees reports. Total expenditures were larger than income by the sum of $11,401.51.

The Fifteenth Edition of the American Medical Directory contains the names of 188,916 physicians of the United States and Canada. More than 13,000 new names appeared in this edition, while approximately 8,000 names which appeared in the Fourteenth Edition were dropped because of deaths.

A review of activities of the Council on Foods during 1938 emphasizes again the continued coöperation of members of the food industry. Few products have been accepted without requiring changes in nutritional claims on labels or in advertising and very few products have been rejected because producers were unwilling or unable to meet the requirements. In a study of the comparative value of the vitamin C potency of canned fruit juices it was found that accepted products compare favorably with fresh juices and rate as excellent sources of the antiscorbutic factor. The Council has prepared brief accounts of the principles which underlie the selection of an adequate diet, one such report having been published in the A. M. A. Interns' Manual. In coöperation with the Council on Pharmacy and Chemistry there was published in *The Journal* a series of noteworthy articles on the vitamins prepared by prominent investigators in the field.

Briefly, the important work of the Council on Physical Therapy for 1938 has been directed toward the consideration of radium and radon seeds, artificial limbs, audiometers, hearing aids, x-ray apparatus and the study of radio interference caused by electromedical equipment.

The interference of radio communications by electromedical equipment was one of the important subjects coming before the Council. A joint meeting was held at which members of the medical profession, representatives of the manufacturers of electromedical equipment, of radio manufacturers and of other interested bodies, and officials of the Federal Communications Commission were present.

The Advisory Committee on Advertising of Cosmetics and Soaps has continued to pass on preparations on which its advice has been requested. There is no doubt that a decided change has been noted in the advertising of many of the cosmetic firms, owing in large measure to the advent of the new Food, Drug and Cosmetic Act but in small measure also to the activities of this committee. The committee has been called on for advice from many sources. Although the committee has not published any articles over its name, it is pleased to report that many of the firms with which it has dealt have revised their literature completely and effectively.

The Bureau of Health Education during the year handled 5,474 communications from doctors, medical societies and coöperating agencies, 8,220 inquiries from the lay public and 1,145 pieces of radio audience mail. It broadcast thirty-seven dramatized radio programs in coöperation with the National Broadcasting Company. The radio library furnished scripts to 128 county medical societies and twenty-one state medical associations, distributing a total of 5,540 scripts covering 876 titles.

The Bureau of Medical Economics reports that medical societies in forty-five states and Washington, D. C., are participating in the study of medical care conducted by the American Medical Association under the direction of the Bureau. Already 416 county medical societies in thirty-six states with the coöperation of other agencies and organizations have completed a study of the need and supply of medical care in their communities. . . .

The Committee on Therapeutic Research, a standing committee of the Council on Pharmacy and Chemistry, which encourages scientific investigations in the field of therapeutics or treatment by providing funds for the prosecution of necessary research, reports that during 1938 it issued thirty-seven new grants.

TWENTY-FIVE YEARS AGO†

EXCERPTS FROM OUR STATE MEDICAL JOURNAL

Vol. XII, No. 5, May, 1914

From Some Editorial Notes:

The Santa Barbara Meeting.—The annual meeting of the State Society, held last month at Santa Barbara, was a distinctly successful one, and the attendance was rather larger than is usual for Santa Barbara meetings. . . .

The plan presented by the Council for handling the insurance situation (industrial accident), was adopted without the slightest change and, together with the fee bill which was endorsed, will be found on pages 196a, 196b, 196c.

* * *

Ideals.— . . . It is a commonplace observation that the men who are today being graduated from our medical schools come forth far better equipped for the practice of their art than were those mustered into its ranks some years ago. Thus premised, is it not to be deplored that the average medical practitioner is not a man of general culture, as we would have all members of a learned profession be? The world and its work was never better worth preparing for than now, for in science especially a new renaissance is arriving; the mysteries of natural law and human potency are being rapidly unveiled. The knighthood of the "Quest of Life" enrolls in the order of psychic and mechanical investigation and presses on to new accomplishment. Though neither wins the "Grail," each wins nearer to its laws. . . .

Education is to enjoy the best and know the best, as well as to produce the best. The degree of a learned profession should be something better than a meal check. It has been said, with some truth, that the allurements of Mammon are too often permitted to call our ingenuous youth from the proper business of school and college. Short roads tempt them to abandon the broad work of education and to go prematurely to schools of professional and technical instruction. The consequence is, the sending forth of half-educated men to plead the causes, to heal the diseases, and to lead the thinking of this generation.—J. Dennis Arnold.

* * *

The Fee (Industrial Insurance) Schedule.—In looking over and thinking about the fee schedule agreed upon and recommended by the Council of the State Society, there are a number of points to be taken into consideration:

It is not a schedule of flat fees for all cases.

It is a list of minimum fees appropriate for workmen earning not over $1,000 a year.

It does not cover everything; special cases need special consideration.

It is not put out as a contract to flat fees for which physicians must treat everybody injured.

The total amount received by our members per year will be very much more than what they get now.

Any member of the Society may be called in, if he wishes to do the work.

Any member has a chance to keep his patient and treat the injured one, if he wishes to do so, other things being equal.

It is especially understood and provided that unusual work shall receive adequate compensation.

It is essential that all bills be itemized and not "padded." Dressings used should be entered on the bill and a reasonable charge made for them.

All contracts to furnish medical services at wholesale are abolished.

(Continued in Front Advertising Section, Page 15)

BOARD OF MEDICAL EXAMINERS OF THE STATE OF CALIFORNIA†

By Charles B. Pinkham, M.D.
Secretary-Treasurer

News

"Governor Culbert L. Olson has announced the reappointment of Dr. Frederick R. DeLappe of Modesto, Stanislaus County, as a member of the State Board of Medical Examiners. Other appointments include: Dr. Franklin Morris of Oakland as a member of the State Board of Chiropractic to succeed Dr. Roy Labouchotte of Redwood City, San Mateo County; Dr. Charles E. Hobrecht, San Francisco, to the State Board of Optometry, succeeding Dr. Geoffrey Davis of Sacramento; Dr. L. E. Pike of Long Beach to the State Board of Examiners in Veterinarian Medicine, succeeding L. G. Clark, and Mrs. Tillie Klob of Los Angeles to the State Board of Cosmetology, succeeding Mable C. Manzell." (Sacramento *Bee,* April 6, 1939.)

"Of 1,063 foreign physicians who took the state medical examinations in New York during 1937 and 1938, 622 were successful. The largest number of candidates (422) came from Germany, of whom 210 failed to pass. Austria furnished 112, of whom 35 failed. Of 488 graduates of New York medical schools, 5.5 per cent failed and of 285 from schools of other states, 24.9 per cent failed." (*Federation Bulletin,* March, 1939.)

"Dr. John R. Brinkley, who made a fortune from old men seeking the vitality of youth, was denied damages today by a federal jury which decided he was not libeled in Dr. Morris Fishbein's article challenging his abilities as a surgeon. He had asked $250,000 for 'the shame, humiliation and embarrassment' which he charged Fishbein's article caused. The verdict was for the defendant, and Brinkley, from his Little Rock, Arkansas, hospital, said his lawyers will file an appeal immediately. Fishbein's defense was that he wrote the article, published in the American Medical Association magazine, *Hygeia,* as a warning to the public. From the witness stand he reiterated every statement incorporated in it, declared each is 'based on fact.' Brinkley introduced a number of former patients, principally old men, who said he had aided them in their search for sexual revitalization. Brinkley, himself, testified that, while goat gland operations proved successful in the restoration of human vitality, he had long since discarded the technique in favor of 'better' methods." (Sacramento *Bee,* March 30, 1939.) (Previous entries, July, October, 1930; September, 1931; April, 1934; May, 1936.)

"After sixty days of figuring, the municipal employees Health Service System yesterday worked out a balance sheet for its January operation and revealed that doctors received $22,873.69 for service valued at twice that sum, even under the low rates set by the Health Service System. In announcing the 50 per cent reduction, system officials were 'so sorry.' They even expressed the hope that the deficiency might be made up 'some time in the future.' They based their admittedly slim hope on the possibility that the amount of illness among municipal employees would drop greatly during the summer months and thus permit the system to build up a surplus. Meanwhile, the medical director's office was attempting to determine whether a slash of doctors' fees for February service would be necessary. No estimates were available. With hospital and clinical fees totaling $8,923 paid 100 cents on the dollar, the doctors were

(Continued in Front Advertising Section, Page 34)

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† This column strives to mirror the work and aims of colleagues who bore the brunt of Association activities some twenty-five years ago. It is hoped that such presentation will be of interest to both old and new members.

† The office addresses of the California State Board of Medical Examiners are printed in the roster on advertising page 6.

Baxter's are pure and safe . . . always ready when you need them

When your patients need intravenous dextrose or saline solutions . . . in a hurry . . . when delays might have serious consequences . . . then you can appreciate the *readiness* of Baxter's Intravenous Solutions in Vacoliters.

For every liter of Baxter's is as pure and safe *when you use it* as it was the day it was made.

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Shaw Surgical Co.	*Portland*
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Chief of Staff

FRANK SCHMIDT
Superintendent

TWENTY-FIVE YEARS AGO

(Continued from Page 30)

and particularly the fact that Colonel Robert H. Elliot of London, England—formerly of the Indian Medical Service, Superintendent of the Government Ophthalmic Hospital of Madras, and Professor of Ophthalmology in the Medical College, Madras, India—will be present as guest of the Society. Colonel Elliot will deliver an address and will demonstrate his operative methods, including his trephining operation for glaucoma.

Other well-known surgeons will be in attendance and a very successful meeting is assured. The officers and committees of the Society extend a cordial invitation to all ophthalmologists and oto-laryngologists to attend the Seattle session. The time is during the most beautiful part of the delightful summer season in the Puget Sound country.

The territory embraced by the membership of the Pacific Coast Oto-Ophthalmological Society includes the states west of the Rocky Mountains and British Columbia. At the last meeting, held in Portland, Oregon, in July, 1913, the program included a paper by Prof. Ernst Fuchs of Vienna. The meeting was most profitable and very enjoyable.

We beg to suggest that in the announcement you give due prominence to Colonel Elliot's coming, as this will undoubtedly interest many, both those who had the pleasure of seeing him during his recent visit to this country and those who were unable to see him.

Thanking you in advance for the courtesy, I am

Yours very truly,
Walter K. Seelye,
Chairman, Program Committee.

From "Deaths Following Injection of Neosalvarsan in Los Angeles."—Last week (the Journal, March 14, 1914, p. 861) we noted the deaths of seven patients in the Los Angeles County Hospital, following intraspinal injection of neosalvarsan. At that time we stated that a fuller report would be published later. We have since received by wire from our special correspondent the following statements from Dr. C. H. Whitman, superintendent of the hospital, and Dr. A. T. Charlton, pathologist, which embody the substance of a report made by them to the Los Angeles County Board of Supervisors: . . .

BOARD OF MEDICAL EXAMINERS

(Continued from Text Page 392)

given the $22,873.69 as payment on bills that were just twice that amount. Despite the reduction in the fee payments, the medical men were not given all the money available. The statement reveals a $301.47 'surplus' in the medical fund for the month. Administrative costs totaled $2.321.20 for the month. Included were personal service charges of $1,541.43, which include the salaries of Cameron, his staff, and Dr. W. P. Coffey. The fund showed an accumulated balance of $1,000.18 that may go to doctors to meet their unpaid charges after a year's operation. . . ." (San Francisco *Examiner*, April 5, 1939.)

"Mrs. Lena Mareck has 'beat' another illegal operation charge, Superior Court records disclosed yesterday. The 54-year-old woman. mother of a Folsom lifer, was freed by Superior Judge Alfred J. Fritz of a charge that she performed a fatal operation upon Mrs. Dolly Murray, twenty-one, last December 29. . . . Police had accused Mrs. Mareck after the girl, admitted to Peralta Hospital in Oakland, allegedly had given evidence that she underwent the operation at Mrs. Mareck's address, 819 Ocean Avenue (San Francisco). Mrs. Mareck first was accused

(Continued on Page 36)

HIS FIRST CEREAL FEEDING

The baby's first solid food always excites the parents interest. Will he cry? Will he spit it up? Will he try to swallow the spoon? Far more important than the child's "cute" reactions is the fact that figuratively and physiologically this little fellow is just beginning to eat like a man.

PABLUM is now being fed to infants as early as the third or fourth month because it gets the baby accustomed to taking food from a spoon, but, more important, Pablum early adds essential accessory food substances to the diet. Among these are vitamins B_1 and G and calcium and, equally essential, iron. Soon after a child is born its early store of iron rapidly diminishes and, as milk is poor in iron, the loss is not replenished by the usual bottle-formula. Pablum, therefore, fills a long-felt need, for it is so well tolerated that it can be fed even to the three-weeks'-old infant with pyloric stenosis, and yet is richer than fruits, eggs, meats, and vegetables in iron. Even more significant, Pablum has succeeded in raising the hemoglobin of infants in certain cases where an iron-rich vegetable failed. Pablum is an ideal "first solid food." *Mothers appreciate the convenience of Pablum as it needs no cooking. Even a tablespoonful can be prepared simply by adding milk or water of any temperature.*

Pablum consists of wheatmeal (farina), oatmeal, wheat embryo, cornmeal, beef bone, alfalfa leaf, brewers' yeast, sodium chloride, and reduced iron.

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Shaping each pad to conform to the hernial region permits the covering of a broader surface and the use of softer material.

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"Two Generations of Appliance Makers"

BOARD OF MEDICAL EXAMINERS

(Continued from Page 34)

of performing an illegal operation in 1934. That same year she was named in a damage suit claiming she had posed as a doctor to perform an operation in another case. She was named in still another case January 17, but the other woman refused to sign a complaint, police said. . . ." (San Francisco *Examiner,* April 11, 1939.) (Previous entries, February, 1927, and November, 1934.)

"Dr. John E. Baker, former Hollywood police surgeon, was on parole yesterday from San Quentin prison. The surgeon said he will be a research chemist, but declined to explain where he will work. He was sentenced on November 6, 1937, for one to ten years after conviction of conspiring to defraud an insurance company through a fake accident ring." (Los Angeles *Times.* April 5, 1939.) (Previous entries, February, 1935.)

"The United States Circuit Court of Appeals today held that 'wire-tapped' intra-state telephone messages may be admitted in evidence in a decision affirming the conviction of two doctors, a lawyer, and an insurance agent on charges of fraud. The four were found guilty of defrauding insurance companies through the filing of fake disability claims. The decision was the first of its kind in this circuit dealing directly with intra-state messages, and an appeal was expected. The defendants, Dr. Maximilian Goldstein, Dr. George Krupp, Joseph J. Weiss, an attorney, and Martin Gross were convicted by a Federal Court jury March 7, 1938. Weiss and Gross were sentenced to terms of three years and the two doctors were sentenced to a year and a day each." (Associated Press dispatch dated New York, April 10, and printed in the San Francisco *Examiner,* April 11, 1939.)

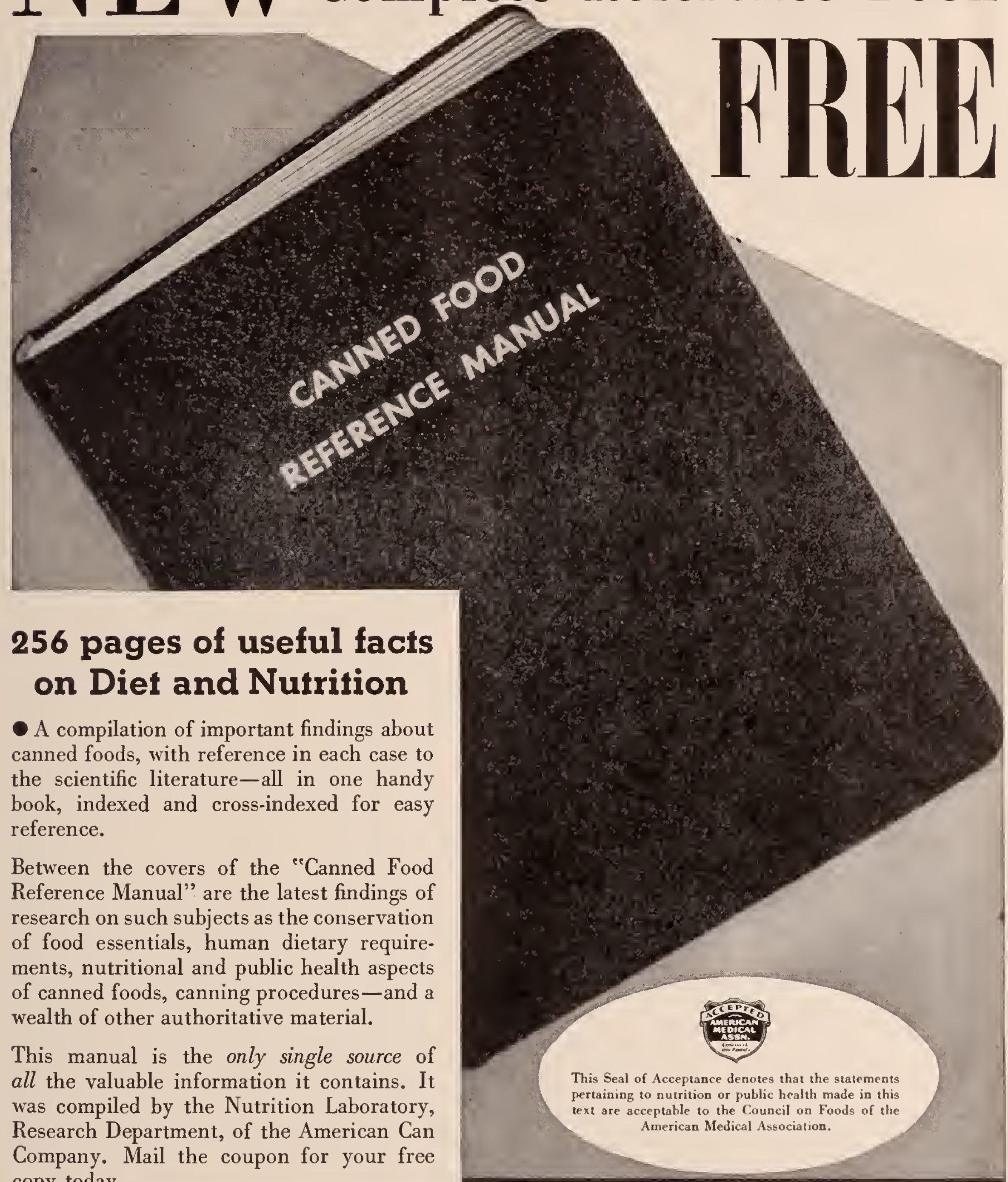
"A prominent Wilshire district physician and a 35-year-old salesman were indicted by the Federal Grand Jury yesterday on charges of illegal sale of narcotics and conspiracy to violate the narcotics law. Named were Dr. R. W. Harris, fifty, who maintains a large suite of offices at 5410 Wilshire Boulevard, and Harry Cruye, salesman, of 930 Santee Street. . . . George Gyllenhammer, agent in charge of the federal narcotics division here, said Cruye allegedly obtained supplies of drugs from a mixture of opium and olive oil purchased from Doctor Harris." (Los Angeles *Herald and Express,* March 30, 1939.)

"A sentence of a $100 fine or thirty days in jail was imposed yesterday on Vern V. Anson, forty-eight, of San Francisco, accused of practicing medicine without a license. T. P. Hunter, State Board of Medical Examiners investigator who arrested Anson Friday night, told Municipal Judge Theresa Meikle that Anson claimed to treat 141 ailments, varying from itch to malaria, to a stiff neck, with diet and violet rays. Hunter said he had taken some ray 'treatments' from Anson and that his eyes were not protected from the light, with consequent temporary blindness. Anson had an office at 323 Geary Street and lived in a hotel at Jones and Eddy streets." (Oakland *Tribune,* March 26, 1939.)

"Karl J. Weberg, middle-aged chiropractor found guilty by a police court jury of violating medical laws, was sentenced to 180 days in jail, which was suspended, and ordered

(Continued on Page 38)

NEW Complete Reference Book FREE



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BOARD OF MEDICAL EXAMINERS

(Continued from Page 36)

to pay a $150 fine Saturday. The doctor was convicted of charges of possessing a hypodermic syringe and needle and advertising himself as a practitioner of naturopathy. . . . The charges of violating medical laws were filed against Weberg after he was acquitted in justice court a few months ago of performing illegal operations. Several years ago Weberg was acquitted of murder charges which were filed against him when a patient upon whom he was alleged to have performed an illegal operation died." (Pasadena *Independent,* March 20, 1939.) (Previous entries, July, August, and September, 1926; February, 1928; April, 1936.)

"Jackson L. Martin, Fresno, was fined a total of $1,000 when he appeared in Federal court here today on charges of income tax evasion. Judge Michael J. Roche fined Martin $200 on each of five counts and assessed an additional $12.50 for the cost of prosecution. The case alleged income tax evasion during the period 1932 to 1936. Martin told the court he had paid the collector of internal revenue $7,953 in taxes, $3,976 in penalties, and $1,800 in interest to cover the alleged evasions. . . ." (Fresno *Bee and Republican,* March 11, 1939.) (Previous entries, December, 1928; February and April, 1939.)

"Arrested for violation of state health laws as part of the drive now being carried on jointly by Dr. J. L. Pomeroy, Los Angeles County Health Officer, and the State Board of Pharmacy and State Health Department, David Hulbert (Hurlbert), age sixty-three, and Olive Hulbert (Hurlbert), age sixty-five, of 2059 Hillhurst, Los Angeles, were today at liberty on $1,000 bail each, pending their jury trial in municipal court March 24. The couple was specifically charged with diagnosing and treating tuberculosis patients without license, violation of the State Medical Practice Act, compounding medicine without permit, violation of state pharmacy laws and violation of the Itinerant Vendors' Act, which prohibits sale of medicine without license. They were also charged with petty larceny with the acceptance of a $25 down payment on a course of treatments for ten weeks at $25 per week. According to Jonathan Kirkpatrick, chief of the Division of Foods and Drugs, Los Angeles County Health Department, who, with Inspector Haydon Dowdy of the State Board of Pharmacy, has been investigating the case for the past two years, the couple has solicited business from advanced cases of tuberculosis and has charged from $350 to $2,000 for a ten months' treatment, promising complete cure. The treatment, it was reported, consisted of the use of coal oil and wintergreen on the chest, coal oil and menthol in the nose, and beef, iron and wine and nux vomica internally. Authorities in the campaign against tuberculosis have received numerous complaints of the operations of the pair, and many cases have been cited in the complaint. The Hulberts were trapped in the solicitation of a patient in Arcadia and then arrested Saturday in Los Angeles upon the acceptance of the $25 down payment and were lodged in Lincoln Heights jail last Saturday, where a few hours later they were released on $1,000 bail each. . . . In addition to the charges already made, another complaint will be filed by the county health department in Arcadia, charging the couple with selling mislabeled and misbranded drugs." (Monrovia *News-Post,* March 3, 1939.)

"A physician and surgeon is legally without authority to use the name of a deceased medical practitioner or use other names than his own in connection with the announcement or actual practice, Attorney-General Earl Warren ruled

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yesterday in an opinion requested by Charles B. Pinkham, Secretary-Treasurer of the Board of Medical Examiners. The Attorney-General cited the Business and Professions Code, holding in part that the use of any fictitious name or any name other than his own by a holder of any certificate in advertising or any sign in connection with his practice constitutes unprofessional conduct. Adding weight to his opinion, the Attorney-General discussed a New York court opinion in which a licensed physician advertised under a designation other than his name. The New York law also prohibits such practice. The court in this opinion indicated the purpose of the statute was to 'effect definite identification of the practitioner' so as to prevent injury by fixing responsibility, which may be accomplished by the restraining influence of publicity, as well as by the ready means furnished by subjecting an offender to punitive discipline. 'If the use of such a name in an advertisement in connection with the practice of medicine is improper, so certainly would be the use of the name of a deceased licentiate,' the attorney said in conclusion." (San Francisco *Recorder*, March 25, 1939.)

"Maintenance of a chiropractic ward of fifty beds in the Los Angeles General Hospital is not looked upon with favor by the Hospital Advisory Committee. The committee was asked to study the request of chiropractors by the Board of Supervisors. . . ." (Hollywood *Citizen-News*, March 22, 1939.)

"Legal machinery to compel the Health Service Board of San Francisco to include chiropractic treatment in its service was put in motion yesterday when Lloyd H. Garrison, Chiropractor, and Muriel M. S. Pettit, teacher, brought suit in Superior Court, seeking a writ of mandate. The petition asks that provisions be made in the System for inclusion of the petitioner under Plan No. 1, which is now in operation. Recently members of the System voted against payment of an additional assessment which would finance services by chiropractors and osteopaths. . . ." (San Francisco *Recorder*, March 8, 1939.)

"Similarity of two bank watchman murders—here and in San Diego—offered today possible solution of the two-year-old search for the slayer of Joe Marenco, thirty-seven, janitor at a Haight-Fillmore branch bank. Arrest in San Diego of 'Dr.' Robert Perry, sixty, who confessed the murder of a bank watchman in that city, led local police to reopen the investigation of the slaying of Marenco in 1936 by a 'paper bag' masked bandit. . . . Perry, also known as William A. Wilson, alias D. C. Balfour, was wanted by San Francisco police on a morals charge, and by the State Medical Board on charges of posing as a doctor at the time of his arrest in the south. It was a teletype message to local police asking the charges against him which revealed the similarity in the two slayings. In both cases the slayer donned a paper-bag mask and awaited the arrival of bank employees after killing the watchman and taking his keys. Perry, according to his record in local police files, posed often as a physician and was arrested in Palo Alto May 10, 1930, for violation of the State Medical Practice Act. . . ." (San Francisco *Call-Bulletin*, March 17, 1939.) In the 1931 Annual Report of the Board of Medical Examiners was printed photograph, fingerprint classification, etc., of Robert Perry, then using the alias Donald C. Balfour and falsely claiming to be the well-known surgeon of the same name connected with the Mayo Clinic, Rochester, Minnesota.

(Continued on Next Page)

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(Continued from Preceding Page)

"Dr. T. Maud Ramer, woman physician, today was free of abortion charges, having been acquitted in Superior Judge Edward J. Kelly's court by a jury of ten women and two men after about four hours' deliberation. Doctor Ramer was alleged to have performed an illegal operation on Mrs. Edith Ann Montieth, young housewife. The defendant brought testimony to show that the young woman had been operated upon two months before she treated her and that her administrations were in no way illegal. The woman physician wept audibly as the jury returned the verdict. The decision was the climax to a trial which lasted nearly three weeks." (San Diego *Tribune,* March 14, 1939.)

"A remedy that assertedly proved far more painful than the ailment provided the basis for a damage suit filed yesterday by an Oakland printer against an East Bay health institute and a staff doctor. Elmer H. Jernigan, forty, of 2125 Thirty-fifth Avenue, charged in his plea for $15,266 damages that J. E. Sivils prescribed a chiropractic treatment at the Basic Health Institute and 'manipulated his body with such force and violence' that he broke Jernigan's sixth rib." (San Francisco *Examiner,* March 23, 1939.)

"Superior Judge Peter J. Shields today refused to tell two Sacramento chiropractors just how far they could go legally beyond the ordinary practice of chiropractic without being arrested. The chiropractors, Percy Purviance and H. B. Clarke, filed a 'friendly suit' designed to force a court opinion setting the limits of the practice of chiropractic in California. 'What they want,' Judge Shields stated in an opinion, 'is to know just what may be done without danger of prosecution. This no court can tell them.' The opinion points out a chiropractor's license gives the holder permission to practice chiropractic 'as taught in chiropractic schools or colleges.' . . ." (Associated Press dispatch, dated Sacramento, March 17, and printed in the San Francisco *Chronicle,* March 18, 1939.) (Previous entries—Percy Purviance—December, 1925; January, February, June, July, September, October, 1926; February, 1927; March, April, July, September, 1928; June, 1932; May, June, and November. 1934; April, August, September, and November, 1935.)

Brain Infection by Fungous Parasite.—The first reported case of infection of the brain by coccidioides (a fungous parasite) in the vicinity of Tucson, Arizona, is described by B. P. Storts, M. D., Tucson, in *The Journal of the American Medical Association* for April 8.

The infection, which occurred in a girl of 4, presented symptoms resembling those of a brain tumor. They consisted of vomiting, headache, unsteady gait, nausea, staggering and pain in the legs.

An exploratory operation showed that a part of the brain, the cisterna magna, was covered by a white opaque membrane. This membrane blocked the passage of spinal fluid and caused a large cyst. The diagnosis was coccidioidal granuloma or tumor. However, the disease could not be checked and the child died. At autopsy it was seen that the membranous growth recurred at the base of the brain and adhered to the brain substance. Also a nodule, containing coccidioidal parasites, was found in the right lung.

The author wonders why this child should have had a coccidioidal infection. She had lived her entire life in Tucson, where the parasite is not generally found. It is of interest that her father maintains a cleaning and pressing establishment and the child frequently rode with him in the delivery wagon, using dirty clothes as a cushion. Parasitic diseases are said to be more common among people engaged in this type of work.

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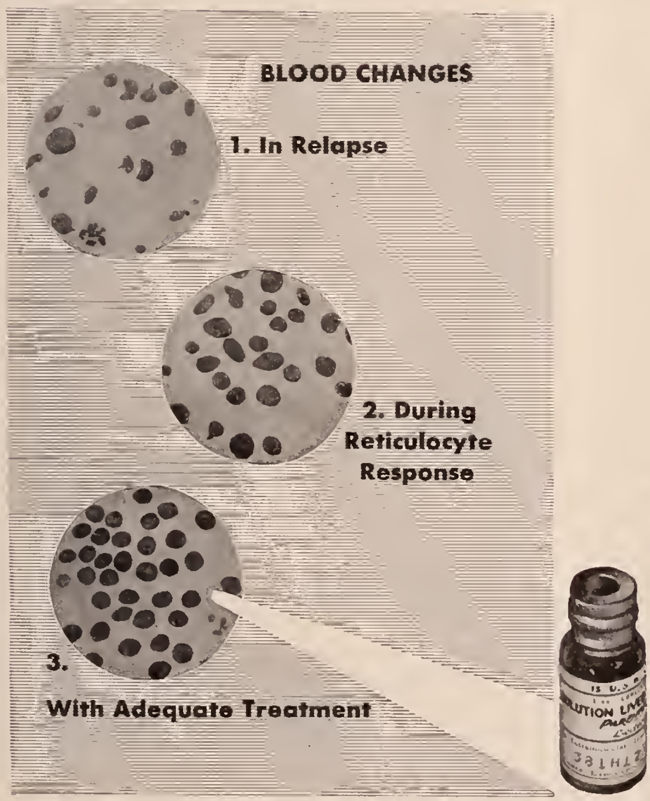

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4	53-104	3.9	5.26
15	105-156	3.2	5.18
2	157-208	3.9	5.21

Reprinted from "The Use of Concentrated Liver Extracts in Pernicious Anemia" by William P. Murphy, M.D. and Isabel Howard, Jo. A.M.A., January 14, 1939, Vol. 112, pp. 106-110.

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Operating Room Irradiation Reduces Infection Risks. The killing of bacteria in the air in operating rooms by means of irradiation may prove to be an important addition to efforts for eliminating infections of wounds in clean primary incisions, *The Journal of the American Medical Association* for March 18 says in an editorial on "Sterilization of Air in Operating Room."

Pointing out that modern aseptic technic in the operating room has almost eliminated infection of wounds in clean cases, *The Journal* says, however, that the introduction of major surgical procedures involving exposure of large raw areas for a long time has again raised the problem of occasional infection.

"Recently," the editorial continues, "Deryl Hart, M.D., of the Duke University School of Medicine, has reported studies during the past five years of efforts to eliminate the occasional sporadic operating room infection. After carefully checking all possible sources of infection, Hart concludes that the least controlled source of infection was air-borne bacteria. Most of the infections were caused by Staphylococcus aureus-haemolyticus. The organisms entered the wound from the air rather than from the skin of the patient. The air was contaminated by operating room personnel and patients.

"The personnel of the operating room and the general population were found at times to have Staphylococcus aureus in the nose and throat in as high as 78 per cent of the cases. In every case of infection in which cultures of the air had been taken the organism cultured from the wound was identical with the one cultured from the air during the operation.

"The bacteriologic studies carried on daily convinced the author that the most important source of wound infection was not the bacteria present in the skin but the organisms eliminated from the noses and throats of the operating room personnel. The wearing of thick gauze masks was not apparently an adequate protection against this source of contamination. To eliminate this source the author turned to air irradiation.

"At the request of the author, a special radiant energy apparatus was designed and constructed which answers the requirements. An operating room was equipped with eight of these lamps, each 30 inches long. The author found that it was possible, with eight tubes operating, to kill a lightly sprayed culture of Staphylococcus aureus-haemolyticus on blood agar plates within sixty seconds or a heavily sprayed culture within less than five minutes. Practically all organisms exposed to the radiation from these tubes at a distance of 8 feet from the center of the cluster were killed within less than ten minutes, and at a distance of 10 feet within less than thirty minutes."

In a series of 132 individual stages of chest operations on fifty-nine patients performed in a field of air sterilized by means of bactericidal radiant energy, Doctor Hart was able to report a lowering to one half of mortality due to infected wounds. There was an incidence of 3.8 per cent of skin infections as compared with 33 per cent in a previous series of 100 similar operations. The incidence of elevation of temperature after the operation was lowered so that more than two-thirds of the patients did not have more than two recorded elevations above 100.4 F. as compared to one-third of the patients without radiation in this group.

In a later report, Doctor Hart presents an analysis of the results obtained in 456 clean primary incisions and eighty-six reopened clean incisions out of more than 800 operations performed in field of bactericidal irradiation. The analysis reveals that postoperative infections have been reduced more than 85 per cent. The occasional death anticipated from infection of a wound did not occur. The number of patients with postoperative temperature above 100.4 F. has been reduced in chest operations from 68 to 30 per cent, in mastoid operations from 46 to 34 per cent and in hernia operations from 36 to 22 per cent. The number of patients with a temperature above 99.2 F. for more than four days after operation has been decreased in chest cases from 78 to 22 per cent, in mastoid cases from 54 to 21 per cent, and in hernias from 46 to 14 per cent. There has also been noted a more rapid wound healing, a lessened systemic reaction and a shortened convalescence.

"The bacteriologic studies carried out by Hart and his co-workers, as well as the practical results obtained, seem to establish that air is an important source of contamination in every operative wound," the editorial concludes. "They demonstrated further that sterilization of the air in the operating room can be accomplished by bactericidal irradiation."

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Radio Short Waves Now Used in Giving Fever Treatment.—The use of radio short waves to produce artificial fever for the treatment of disease is a striking demonstration of the relationship of progress in various fields of knowledge, Richard Kovacs, M. D., New York, declares in the May issue of *Hygeia,* the health magazine.

Such diseases as gonorrhea, St. Vitus' dance, some forms of arthritis and of bronchial asthma, sinus disease and neuritis are being successfully combated by short wave treatment, the author points out.

Describing the method employed, Doctor Kovacs explains that local heating of any part of the human body is produced by placing it in the energy field of a short wave radio set.

This method is known as short wave treatment or short wave diathermy. An older method of diathermy involves the placing of plates in direct contact to the body or an extremity and the passing of a high frequency electric current through the afflicted part. The newer form of diathermy has the advantage that it can be applied to practically any surface or part of the body and its heat effect is more uniform.

"Fever treatment must be combined with other recognized forms of treatment, by diet and if necessary by surgery," the author observes. "Experienced medical advice and skilled nursing care are more important in administering artificial fever than the best apparatus in unskilled hands.

"The large majority of medical men agree that it is the well directed and well controlled deep heating effect of radio waves on the human body which brings about relief. The idea that certain wavelengths exert special effects on certain diseases is untenable or at least not proved."

For the man listening to his radio, Doctor Kovacs admits, the use of radio waves for medical treatment is sometimes anything but a blessing. "When some of the apparatus used for treatment is improperly constructed," he explains, "it may become a nuisance not only for every radio set which derives electricity from the same power line, but for those within several miles.

"Steps are under way to abate such nuisance by coöperation of the medical profession and reliable manufacturers of medical equipment. All apparatus may be properly screened to minimize interference, or a special wavelength may be allocated for treatment purposes.

"Induced fever," says the author, "has proved especially effective in diseases caused by so-called 'parasitic' germs. Some germs, such as those of gonorrhea, have become so completely used to living in the human body at its normal temperature that an increase of temperature by a few degrees affects them.

"Artificial fever maintained for some hours either directly destroys the germs of gonorrhea or sufficiently stimulates the natural defensive forces of the body to stop the further growth of germs.

"In joint inflammation or arthritis caused by gonorrhea, almost dramatic relief from pain and swelling can be accomplished by artificial fever. Similar results have been accomplished in gonorrheal inflammation of the eye and in stubborn infections of the pelvic organs in both women and men.

"Fever treatment is also effective in the disease of children, known as St. Vitus' dance, as well as in certain forms of bronchial asthma resisting all other forms of treatment.

"Short-wave diathermy is employed by physicians for treating inflammatory conditions of inner organs and of joints. These include some forms of arthritis, sinus disease, and rheumatic conditions such as neuritis. Repeated treatment by diathermy brings about an increased flow of blood, which speeds up the return of normal function; it also relieves pain due to nerve irritation."

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Pneumococcic Meningitis. — Four recoveries out of seven cases of pneumococcic meningitis treated with sulfanilamide are reported by Barbara A. Hewell, M.D., and A. Graeme Mitchell, M. D., Cincinnati, in *The Journal of the American Medical Association* for March 18.

This disease is an infection of the meninges, or membrane coverings of the brain and spinal cord, by a pneumococcic organism.

A review of the literature up to 1927 shows 150 authentic recoveries from this disease, the authors say. Approximately thirty additional recoveries have occurred during the years 1927 to 1937. Most of these have been attributed to spinal drainage and the administration of antipneumococcus serum or the drug, ethylhydrocupreine, but in general results with these treatment measures have been unsuccessful.

The authors point out that "in the ten years preceding 1937 there were in the Children's Hospital of Cincinnati and in the pediatric service of the Cincinnati General Hospital twenty-three children suffering from pneumococcic meningitis, the mortality in this group being 100 per cent. Since the use of sulfanilamide four of seven patients with the condition have recovered."

Stating that there are at least thirty cases of recovery from the disease, including four observed by them, in which part of the treatment consisted in the use of sulfanilamide or related compounds, the authors say that "it appears reasonable to conclude that sulfanilamide was responsible for these recoveries, since the mortality rate was so high with other forms of treatment. Recovery occurred with the use of different compounds, such as prontosil, sulfanilamide and sulfapyridin; that is to say, the data now available do not

(Continued on Next Page)

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Clinical study has shown DIAL with Urethane to be useful in obstetrical analgesia. (Van Del, D. T., *Jl. Missouri State Med. Assoc.*, March, 1938.)

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(Continued from Preceding Page)

permit conclusions concerning the relative merit of these different compounds in the treatment of pneumococcic meningitis.

"There are at least eight cases of pneumococcic meningitis, including three observed by us, in which sulfanilamide was given and in which recovery did not follow.

"Of the patients receiving sulfanilamide who recovered, only one showed pneumococci in the blood culture. Of the eight patients receiving sulfanilamide who died, the blood cultures were positive for seven. This indicates that even with the use of sulfanilamide a blood stream infection with pneumococci is a factor in mortality and perhaps also that with such infection large doses of sulfanilamide should be tried."

Diagnosis of Many Diseases Is Possible Through the Eyes.—Such conditions as diabetes, high blood pressure, inflammation of the kidney, syphilis, tuberculosis, intracranial or brain pressure and optic nerve inflammations often may be diagnosed through the eye long before their presence might otherwise be suspected, Arthur J. Bedell, M. D., Albany, N. Y., says in *The Journal of the American Medical Association* for March 18.

"The background of the eye is the stage on which many of the tragedies of life are enacted," Doctor Bedell states. "By careful repeated examination, early changes can be detected and steps taken to eradicate or diminish the ravages of destructive forces."

This examination is made with a simple ophthalmoscope, an instrument containing a mirror arrangement making possible the examination of the inside of the eye.

The author points out that the recognition of the signs of the above conditions is possible through the major blood

(Continued on Page 48)

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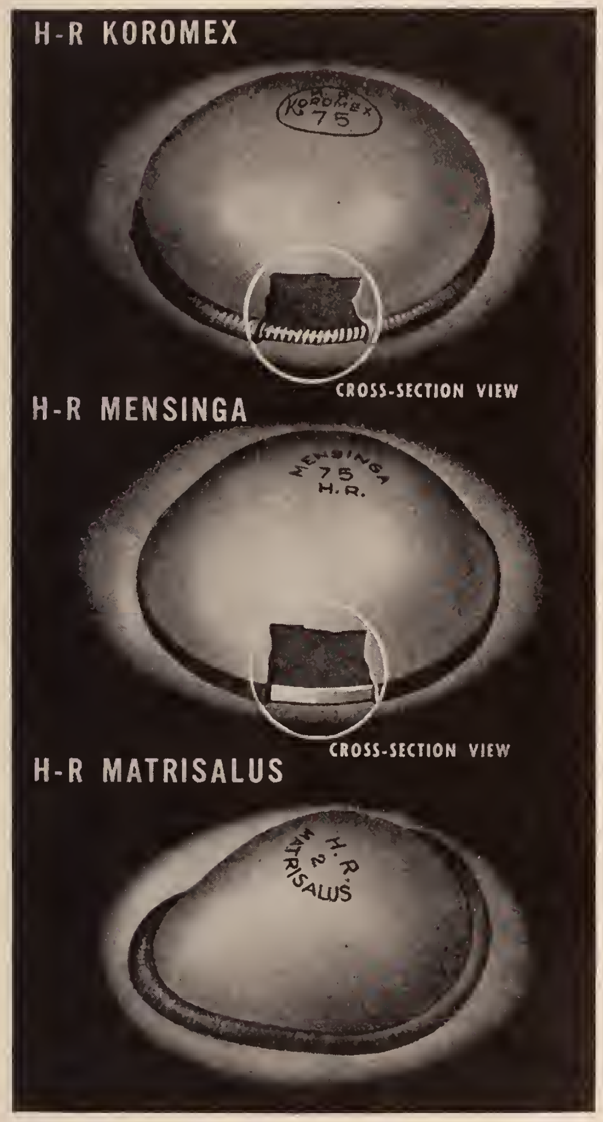

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(Continued from Page 46)

vessel changes and alterations which may be found in the fundus or back part of the eye.

Although the correct interpretation of all of the gross pathologic signs of the above diseases is a lifetime study, Doctor Bedell believes that when sufficiently trained every physician should at least be able to recognize them and by constant daily application should steadily improve his diagnostic capacity.

"The ocular funds is one of the most available regions in the entire human body for the recognition of incipient, advancing and destructive processes," Doctor Bedell declares.

"To the initiated, examination of the fundus discloses important clinical signs, which, when gathered together, form part of the life record of the patient. From the knowledge gained by the study of thousands of such reports, accurate prognostic as well as diagnostic conclusions can be drawn."

Early eye signs of hardening of the arteries and high blood pressure are vein displacement, vein indentation, sometimes a dilatation of the vein between the artery constrictions, an increasing visibility of the artery wall and a coppery reflex in the artery which later becomes a silvery gray and still later a white streak; or the entire artery tree straightens and contracts or the reverse happens and the arteries become more tortuous.

Diabetes may be severe, last for years and finally cause the death of the patient without producing inflammation of the retina. On the other hand, the fundus picture of hard, yellow deposits near the disk or macula combined with small hemorrhages may be the first visible evidence of something abnormal and lead to the investigations which disclose the correct diagnosis. While all the changes found in the fundus of the eye of a patient with diabetes can perhaps be duplicated in a nondiabetic person, the author believes that "the picture of yellow deposits arranged without order and not of uniform size, associated with hemorrhage without marked vessel changes, most strongly suggests diabetes.

"The routine ophthalmoscopic inspection of every patient will lead to the earlier detection of glaucoma (a disease of the eye which hardens it and causes blindness), one of the most serious of all eye diseases. Every physician knows that in glaucoma the central depression in the disk increases in size until in the far advanced stage the entire nerve head is a sunken white cup and the patient is incurably blind.

"Elderly patients frequently complain of inability to read; this is often correctly ascribed to faint lens opacities or partial atrophy of the optic nerve, but sometimes it is caused by a degeneration in the macular region. The earliest signs are recurring hemorrhages around the macula in one eye and then after months or years in the other. This eventuates in the destruction of the central retina and, although the patient is unable to do close work, he never goes blind.

"The seriousness of this situation calls for the mobilization of all physicians in an attempt to understand the method of production, the various stages and, if possible, to combat the underlying factors, which at this time seem to be due to changes in the blood vessels and beyond the range of treatment agents."

Suicides by Barbiturates Have Increased Since 1933. The number of suicides in the United States by means of barbiturates has definitely increased since 1933, although the total number from all causes during this same period has decreased, W. E. Hambourger, Ph.D., Cleveland, declares in *The Journal of the American Medical Association* for April 8.

"The total number of suicidal deaths by the barbiturates in 1936 was probably close to 300," Doctor Hambourger

(Continued on Page 50)

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1 teaspoon	*15 cals.*
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(Continued from Page 48)

reports in his study of the promiscuous use of these drugs and the part they play in suicide. The study was made at the invitation of the Association's Council on Pharmacy and Chemistry.

The number of such suicides in 1937 may have approached or even exceeded 400, Doctor Hambourger believes.

"For the five years 1932-1936 the national incidence of suicides by barbiturates represents 4.2 per cent of all poisons (except gases) and 0.66 per cent of all methods used for suicide.

"In seven large cities and their associated counties, for the decade 1928-1937, barbiturates represent 8.1 per cent of suicides by all solid and liquid poisons and 1.25 per cent of all methods used for successfully committing suicide.

"The incidence of suicides by barbiturates is nearly twice as high in large cities as in the country as a whole, ranging from 2 per cent in St. Louis up to 16.7 per cent in Boston.

"The number of suicides by barbiturates has shown a definite upward trend during the past decade, especially marked since 1933, although the frequency of suicides by liquid and solid poisons and that of total suicides have both declined since 1933.

"More than 1,200,000,000 grains (174,188 pounds) of barbituric acid derivatives were sold in the United States in 1936."

The statistics for the study were obtained from the United States census reports and from data furnished by the Metropolitan Life Insurance Company and medical examiners and coroners of several large cities.

A future report will discuss the incidence of nonfatal poisoning by the barbiturates, chronic usage and the rôle that the drug plays in auto accidents and criminal offenses.

At a meeting of the American Medical Association in June, 1937, a resolution was introduced on the "Evils from Promiscuous Use of Barbituric Acid and Derivative Drugs," in which was included the following statement: "The evils of these drugs include habit formations, toxic cumulative action, their substitution for alcoholic beverages for drunken episodes, their use for successful as well as unsuccessful suicidal attempts, their improper use being a recognized causative factor in many motor accidents and their improper use being a recognized etiologic factor in some criminal assaults."

The Unspecified Prescription.—Some physicians are averse to specifying the maker's name of a proprietary product.

"I invariably specify Mead's whenever I can, for I feel that when I do not specify a definite brand, the effect may be the same as specifying that any brand will do.

"By not specifying exactly, I let down the bars to a host of houses, many entirely unknown to me and others deserving no support at my hands.

"When I specify Mead's, I may be showing favoritism, but at least I know that I am protecting my results. If, at the same time, my self-interested act encourages a worthy manufacturer to serve me better, I can see no harm in that."

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Tuberculosis in Dressed Poultry.—"About 3 per cent of the dressed poultry offered for sale in American markets is infected with tuberculosis," *The Journal of the American Medical Association* for March 18 says.

"In order to test for the possible presence of tubercle bacilli in dressed poultry, W. H. Feldman of the Mayo Foundation removed spleens aseptically from 125 fowls at the time of evisceration by a local dealer. The fowls thus

(Continued on Page 56)

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(Continued from Page 50)

examined included sixty-six young chickens, thirty mature hens, eighteen domestic ducks, four turkeys, three capons and four wild ducks.

"Each spleen was emulsified in 5 cc. of sodium chloride solution, and 1 cc. of the resulting emulsion was distributed over the surface of four tubes of egg yolk glycerin agar. The tubes were incubated at 37 C. for ten weeks.

"Positive growths of acid-fast bacilli were obtained from four spleens. One young chicken, two adult hens and one domestic duck were the sources of these four organs. Subcultures from each of the four cases were inoculated in duplicate into guinea pigs, rabbits and chickens.

"All guinea pigs were without macroscopically demonstrable lesions when killed from six to eight weeks later. Three of the eight rabbits died within two to eighteen days, presumably from intercurrent infection. The five remaining rabbits died or were killed from one to two months later. At necropsy each of the five showed extensive tuberculous lesions. The eight chickens died or were killed at the end of from six to eight weeks, all showing extensive tuberculosis of the so-called Yersin type.

"From this evidence the investigator concluded that each of the four positive spleens was the carrier of virulent tubercle bacilli of the avian type. Since virulent tubercle bacilli are thus present in about 3 per cent of apparently normal fowls and since no practical method of postmortem inspection will disclose their presence, Feldman concludes that the rearing of fowls for food markets should be prohibited in environments known to be infected with avian tuberculosis."

To preserve health is a moral and religious duty, for health is the basis of all social virtues. We can no longer be useful when not well.—Johnson.

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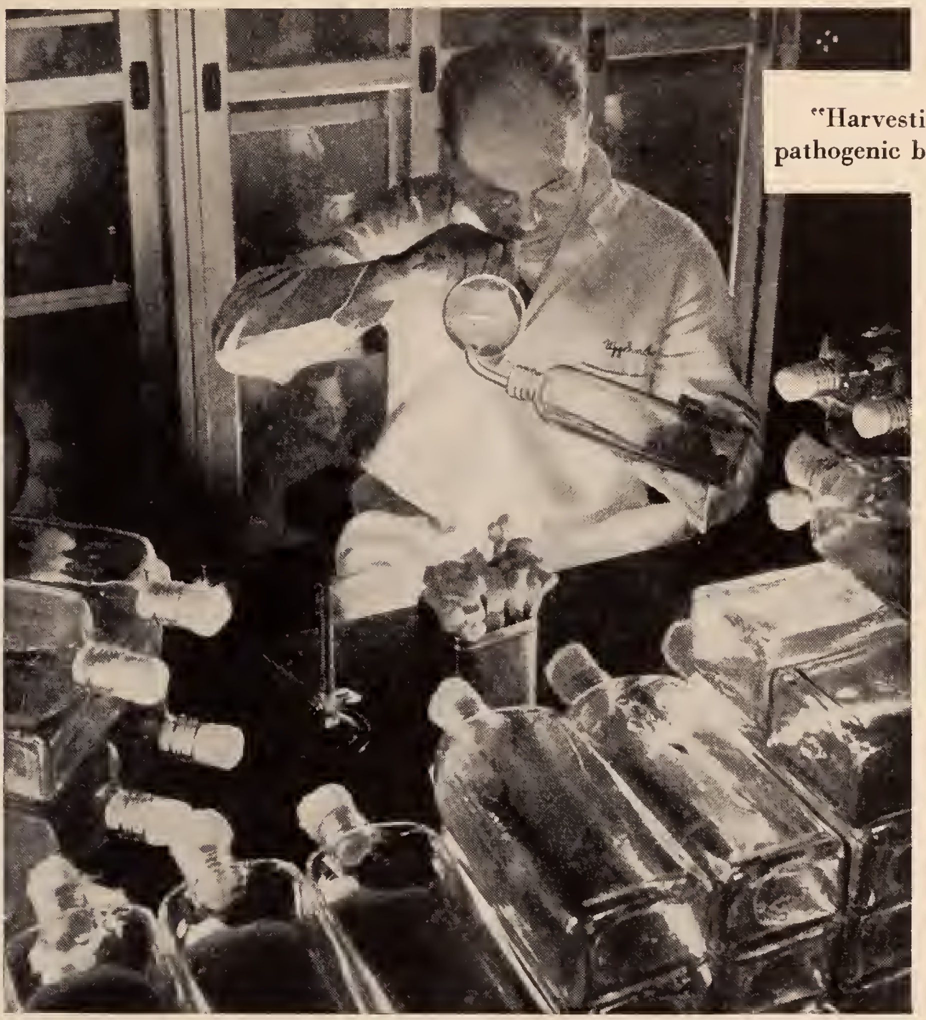

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Underlying Causes of Child's Poor Posture Should Be Attacked.—Instead of constantly exhorting their children to stand up straight, parents should attack the underlying causes of poor posture as well as provide the child with definite posture training, Alvia Brockway, M. D., Los Angeles, advises in *Hygeia*, the health magazine, for June.

The child who slumps generally does so because, for some reason, he is fatigued. In some instances this reason may simply be that he is not getting enough rest to supply his needs for energy. Too many picture shows or radio programs in the evening frequently interfere with proper rest.

The tired demeanor in other cases may be due to enlarged adenoids, diseased tonsils or sinuses, faulty vision or poor elimination.

It is not sufficient, however, to remove sites of infection or to provide good habits for the bad ones which have caused the poor posture. The body curves that have become more or less permanent during the months or years of faulty posture must be realigned.

These children with faulty posture habits can be greatly helped by orthopedic and posture training. They need individual instruction and must be shown over and over again, under direct supervision, which muscles to work and which to relax.

Some of the unfortunate effects of poor posture, aside from the unpleasant appearance produced, are the crowding of the vital organs of the chest and abdomen, which may make the victim especially susceptible to colds and bronchitis, and the crowding of the digestive and eliminative organs in the abdominal cavity, which may result in digestive disturbances and constipation and, if continued for years, may even lay the foundation for colitis, hemorrhoids and gall-bladder disturbances.

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Secretary, Gertrude Moore, 2404 Broadway, Oakland.

Meeting, *Third Monday, 8:15 p. m., Hunter Hall, Oakland.*

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President, E. L. Meyers, Fourth Street and Broadway, Chico.

Secretary, J. O. Chiapella, 131 Broadway, Chico.

Meeting, *Second Thursday.*

Contra Costa County Medical Society

President, Kaho Daily, 314 Tenth Street, Richmond.

Secretary, Clifford E. Dieterich, 1306 Pomona Avenue, Crockett.

Meeting, *Second Tuesday, 8 p. m.*

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Secretary, Lester R. Nielson, 1006 Mattei Bldg., Fresno.

Meeting, *First Tuesday, University-Sequoia Club, Fresno.*

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Meeting, *First Thursday.*

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Secretary, William A. Clarke, Holtville.

Meeting, *Third Tuesday, 7 p. m., Barbara Worth Hotel, El Centro.*

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Secretary, C. S. Compton, 428 C Street, Bakersfield.

Meeting, *Third Thursday, 8:00 p. m.*

Kings County Medical Society

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Secretary, Herbert Archibald, Salinas National Bank Building, Salinas.

Meeting, *First Thursday.*

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Secretary, M. M. Booth, Bruck Building, St. Helena.

Meeting, *First Wednesday.*

Orange County Medical Society

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Secretary, Glenn Curtis, 323 So. Pomona Street, Brea.

Meeting, *First Tuesday, 8 p. m., Chapel of the Orange County Hospital Orange.*

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President, William M. Miller, Auburn.

Secretary, Robert A. Peers, Colfax.

Meeting, *At Call of President.*

Riverside County Medical Society

President, N. K. Bear, 3655 Fourteenth Street, Riverside.

Secretary, Thomas A. Card, 3616 Main Street, Riverside.

Meeting, *Second Monday, 8 p. m., Library, Riverside Community Hospital.*

Sacramento Society for Medical Improvement

President, Manuel Azevedo, 1027 Tenth Street, Sacramento.

Secretary, Glenn E. Millar, 321 Physicians Building, Sacramento.

Meeting, *Third Tuesday, 8:30 p. m., Auditorium, Sacramento.*

San Benito County Medical Society

President, J. M. O'Donnell, Hollister.

Secretary, L. E. Smith, Hollister.

Meeting, *At Call of President.*

San Bernardino County Medical Society

President, Delbert B. Williams, 1151 D Street, San Bernardino.

Secretary, A. E. Varden, Medico-Dental Building, San Bernardino.

Meeting, *First Tuesday, 8 p. m., San Bernardino County Charity Hospital.*

San Diego County Medical Society
Fourteenth Floor, Medico-Dental Building,
233 A Street, San Diego

President, Hall G. Holder, 1109 Medico-Dental Building, San Diego.

Secretary, C. V. Bernardini, Medico-Dental Building, 233 A Street, San Diego.

Meeting, *Second Tuesday, El Cortez Hotel.*

San Francisco County Medical Society
2180 Washington Street, San Francisco

President, Edwin L. Bruck, 384 Post Street, San Francisco.

Secretary, Stanley H. Mentzer, 2180 Washington Street, San Francisco.

Meetings, *Every Tuesday, 8:15 p. m., 2180 Washington Street, San Francisco.*

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President, N. P. Johnson, Medico-Dental Building, Stockton.

Secretary, George H. Rohrbacher, Medico-Dental Building, Stockton.

Meeting, *First Thursday, 8:15 p. m., Medico-Dental Club Rooms, Stockton.*

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President, J. B. V. Butler, 722 Marsh Street, San Luis Obispo.

Secretary, E. M. Bingham, County Health Department, San Luis Obispo.

Meeting, *Third Saturday, 6:30 p. m., Gold Dragon Cafe, San Luis Obispo.*

(Roster lists continued on advertising page 6)

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Secretary, J. Garwood Bridgman, 205 Third Avenue, San Mateo.

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Meeting, *Second Monday.*

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Meeting, *Sunday on call.*

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Meeting, *Second Tuesday, 8 p. m., Casa de Vallejo Hotel, Vallejo.*

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Meeting, *Second Thursday.*

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Meeting, *Second Friday, 7:30 p. m., Hotel Hughson.*

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Meeting, *First Tuesday.*

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*Further Clinical Observations on Feeding Infants Whole Milk, Gelatinized Milk, and Acidified Milk. C. Loring Joslin, M.D., F.A.A.P.; Bulletin of the School of Medicine, University of Maryland; Jan. 1939.

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No Congressional Definition of Naturopathy.—Pointing out the falseness of claims that an act of Congress had defined naturopathy, *The Journal of the American Medical Association* for February 25 says:

"In 1933, naturopaths in Iowa sought special privileges from the legislature in the form of a law to enable them to ply their trade without possessing qualifications adequate to protect the public health. Their bill, which failed of enactment, proposed to define naturopathy 'according to the definition of naturopathy, enacted by the Congress of the United States of America and the District of Columbia.' In the same year, and no doubt in other years, a self-styled 'Examining Board of Naturopathic Physicians, Arizona District,' incorporated under the laws of Arizona, issued so-called 'certificates' to naturopaths, purporting to authorize certificants to 'pursue the practice of naturopathy within the corporate powers of this association.' It claimed to be acting 'under the authority of the American Naturopathic Association' and 'by virtue of the definition of naturopathy as set forth in and by an Act of Congress approved on February 27, 1929, and verified in and by an Act of Congress approved on February 7, 1931, which Act defines naturopathy.'

"In 1938 a petition, which the court denied, was filed in the circuit court of Jackson County, Missouri, to form a corporation with various and sundry powers, including the authority to establish naturopathic schools for the training of students in naturopathy 'as defined by Congress under the provisions of House Bill No. 12169 passed and approved by the Seventy-First Congress of the United States in the year 1930.' On February 8, 1939, a bill was introduced in the legislature of North Dakota proposing to define naturopathy 'as provided by an Act of Congress of 1929.' There seems little reason for doubt that similar statements have been made by naturopaths at other times in other places.

"The fact is, the statements of naturopaths to the contrary notwithstanding, the Congress of the United States has never defined naturopathy. A Healing Arts Practice Act for the District of Columbia was approved on February 27, 1929, which provided for a board of naturopathic examiners. This Act did not define naturopathy, but authorized the Commission on Licensure to Practice the Healing Arts to do so. The definition formulated by the Commission was unsatisfactory to the naturopaths, and on May 5, 1930, they caused to be introduced in the House of Representatives of the Seventy-First Congress a bill, H. R. 12169, to define naturopathy more broadly than it had been defined by the commission. This bill passed the House of Representatives on February 7, 1931. In the Senate it was referred to the Committee on the District of Columbia, where it died with the adjournment of the Seventy-First Congress. No other bill has since been considered by the Congress proposing to define naturopathy.

"The fact that naturopaths have apparently thought it necessary to resort to trickery of this sort to gain their objectives indicates their disbelief in the inherent merit of their cause. It should be an added reason, in any event, why their appeals should receive scant consideration."

The required methods of work are no secret; for they have been employed by thinking individuals ever since the time of Socrates. Here one cannot build without laying foundations. One cannot, for example, be a radio expert without the principles of electricity. One cannot be a business expert without economics. One cannot be an engineer without getting a knowledge of mathematics. Thus it runs throughout the cycle of subjects. Successful work is a kind of development; so before going far one must master its preliminary and prerequisite stages. There is no other valid way. One cannot build a tower without first laying a solid foundation.

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A combined full time course in Urology, covering an academic year (8 months), will be inaugurated on October 1, 1939. It will comprise instruction in pharmacology, physiology, embryology, biochemistry, bacteriology and pathology, practical work in surgical anatomy and urological operative procedures on the cadaver; regional and general anesthesia (cadaver); office gynecology; proctological diagnosis; the use of the ophthalmoscope; physical diagnosis; roentgenological interpretation; electrocardiographic interpretation; dermatology and syphilology; neurology; physical therapy; continuous instruction in cysto-endoscopic diagnosis and operative instrumental manipulation; operative surgical clinics; demonstrations in the operative instrumental management of bladder tumors and other vesical lesions as well as endoscopic prostatic resection.

FOR INFORMATION ADDRESS: MEDICAL EXECUTIVE OFFICER • 345 West 50th Street, New York City

Specialization Is Changing Graduate Medical Education.—"Hospital internships, residencies, and fellowships have gained further prominence of late in view of their relationship to the certification of specialists," *The Journal of the American Medical Association* for March 11 says in an editorial:

"Internships were first to become firmly established as an essential period of hospital training following graduation. They acquired official recognition in 1914, when 508 general hospitals were approved for intern training by the Council on Medical Education and Hospitals of the Association. Since that time there has been a steady expansion of educational facilities, until at present 7,373 internships are available in 734 approved hospitals.

"The certification of specialists, which has held the attention of the medical profession during the last few years, has wrought conspicuous changes in the field of graduate medical education. Most significant has been the rapid increase in number of residencies and fellowships, the change in length and character of training, the introduction of basic science requirements and the evident desire on the part of hospitals to supply instruction on an approved basis. A steadily increasing number of young physicians are seeking the direct approach to specialization without an intervening period of general practice. Their search for specialized training is causing more and more hospitals to enter on courses of graduate instruction. Residencies are of comparatively recent origin and have not yet attained the degree of stability and uniformity which characterizes the intern field.

"In 1927 a separate residency classification was established when 278 hospitals and 1,776 individual residencies were approved. The rapid expansion of educational opportunities has increased the approved hospitals to 503 and the residencies and fellowships to 3,977. Last year the Council extended the residency classification to include fellowship training. In spite of the large number of approved positions there is no indication that a saturation point has been reached in any of the specialties.

"Another development of profound significance is the close coöperation that has been established between the Council on Medical Education and Hospitals, the Advisory Board for Medical Specialties and the individual certifying the boards. Coöperation has already been developed with the American Board of Radiology, the American Board of Pathology, and the American Board of Anesthesiology. As soon as possible a similar procedure will be inaugurated with each of the remaining boards, that uniformity in the investigation and appraisal of educational opportunities may be accomplished. With the aid of the specialty boards a complete revision of the 'Essentials of Approved Residencies and Fellowships' is in process. The educational requirements of individual specialties will then be more definite and more clearly apparent."

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Physical Therapy Course. 18 months. Tuition, $150.00. Given for graduates of accredited Schools of Nursing and Physical Education. Course opens September, 1939.

For benefit of physicians, institutions, and therapists, the School maintains Bureau for placement of therapists fulfilling the requirements of American Medical Association.

Apply: Miss Lily Graham

Director . . . . . School of Physical Therapy

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OBSTETRICS—Two Weeks' Intensive Course, June 19, October 23. Informal Course every week.

FRACTURES AND TRAUMATIC SURGERY—Ten-Day Formal Course, June 19, September 25. Informal Course every week.

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TEACHING FACULTY — ATTENDING STAFF OF COOK COUNTY HOSPITAL

Address: Registrar, 427 South Honore Street, Chicago, Ill.

HOSPITALS AND SANATORIUMS

The Institutions here listed have announcements in this issue of CALIFORNIA AND WESTERN MEDICINE. For Index, see advertising page 8.

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For Treatment of Diseases of the Chest
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FRENCH HOSPITAL
General Hospital
Geary at Fifth Avenue, San Francisco

GREENS' EYE HOSPITAL
Consultation, Diagnosis and Treatment of Diseases of the Eye
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Effect of Alcohol on Kidney Function Reported Negligible.—Alcohol had no significant permanent effects on kidney function in a series of patients with kidney disease studied by Maurice Bruger, M. D., S. Arthur Localio, M. D., New York, and Nobel W. Guthrie, M. D., Hot Springs National Park, Arkansas, they report in *The Journal of the American Medical Association* for May 6.

Their investigation was made, they state, in view of the somewhat conflicting evidence as to the effect of alcohol and alcoholic beverages on the normal and the diseased kidney. Sixteen persons with diseased and five with normal kidneys were examined.

The function of the kidney remained unchanged after the taking of alcohol by persons with acute and chronic diffuse inflammation of the kidney. Alcohol did not delay the recovery of patients with acute diffuse inflammation of the kidney, who showed a gradual improvement in kidney efficiency. Impairment of the function of the kidney was increased temporarily by alcohol in patients with shrunken inflamed kidneys.

Alcohol rarely augmented the proteinuria (protein in the urine) in patients with albumin in the urine (Bright's disease). A moderate increase in urine was frequently induced (this occurred even in patients with marked impairment of the function of the kidneys).

Alcohol did not increase the number of red blood cells and casts in the urine of persons with acute diffuse or with chronic diffuse inflammation of the kidneys.

All subjects were kept at complete bed rest. In subjects with normal kidneys the taking of alcohol was occasionally followed by an increase in the excretion of red blood cells, white blood cells and casts (albumin) in the urine, but the values were rarely elevated above the average normal range. Proteinuria was not induced, nor did any measureable impairment of the function of the kidney occur.

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OTOLARYNGOLOGIST SEEKS CALIFORNIA LOCATION with group or individual. Able make moderate investment. Have license. Certified American Board, Member College of Surgeons. Excellent training here and abroad, including bronchoscopy. Address, Box 300, California and Western Medicine, 450 Sutter Street, San Francisco, California.

WANTED — POSITION AS LOCUM TENENS DURING month of September. Four years of hospital work plus two years of practice. Qualified in surgery. Address, Box 600, California and Western Medicine, 450 Sutter Street, San Francisco, California.

Physicians as Artists.—"From time immemorial, medicine and art have been closely associated. The same skill that makes the surgeon's fingers deft with scalpel and ligature is at work in the beautiful examples of sculpture and carving shown in this book. The eye that so quickly and accurately evaluates the gradations in color and texture between normal and pathologic tissue coördinates the hand that wields the painter's brush. The man who chooses medicine as his life's work is largely motivated by a love for his fellow man, else he would select a vocation offering greater monetary reward. From the beginning, he is trained to exercise his powers of observation, and in time develops imagination, sympathy, understanding, philosophy and reverence, all of which are the very essence of art. Moreover, he deals with that most exquisite form of divine art and beauty, the human body.

"An artist-physician has said: 'The tendency of most persons is to regard the artist with awe as a superman endowed with talents not vouchsafed to the ordinary mortal. Most doctors have a latent artistic sense which may be developed to a remarkable degree by constant practice. When opportunity affords, slip away to the park or country, sit down on a camp-stool and practice sketching from nature. At first the results may not be satisfying, but in course of time you will be gratified to notice a marked improvement. An ample sketching kit may be purchased for a small sum and any local artist will be glad to give you instruction.'

"At the least, every physician is able to develop a sensitiveness to and an appreciation for fine art. He can also cultivate a hobby which if not one of the fine arts, is in the class of 'work by the side of work.' Dr. Charles A. Dana, who has always stressed the value of cultural medicine, has advised: 'Be a collector, for example, of stamps or automobiles, or old books, or neckties or pins; or find diversion in some collateral branch of science; the lore of birds, of fishing and shooting. Make a garden or cultivate shrubs and flowers. These kinds of activities will make your life happier and your professional character more attractive and effective.' "—quoted from "Parergon," published by Mead Johnson & Company, Evansville, Ind. Free copy available on request.

Stabisol: Squibb Bismuth Subsalicylate in Oil.—An improved suspension of Bismuth Subsalicylate in a specially developed oil vehicle has been introduced by E. R. Squibb & Sons, New York, under the trade name, Stabisol.

Each cc. of Stabisol contains 2 grains (0.13 Gm.) Bismuth Subsalicylate, equivalent to 75 mg. metallic bismuth, with 3 per cent Chlorbutanol (local anesthetic) and 0.03 per cent Mercurated Chlorxylenol (antiseptic). The vehicle is 80 per cent specially treated, decolorized olive oil and 20 per cent ethyl oleate, containing small amounts (about 0.015 per cent) of calcium oleate and water to aid in stabilizing the suspension.

Stabisol is supplied in 60 cc. diaphragm cap containers. Advantages of the container are: ease of handling, neatness, avoidance of any contact between metal and solution, and minimum chance of contamination.

The average dose of Stabisol is 1 cc. once a week in courses lasting 8 to 12 weeks, depending upon the individual need and reaction.

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BOOKS RECEIVED

Artistic Anatomy. By Walter Farrington Moses. Revised and Enlarged Edition. Cloth. Pp. 59-b. Price, $3.50. Los Angeles: Borden Publishing Company, 1939.

Transactions of the Forty-third Annual Meeting of the American Academy of Ophthalmology and Otolaryngology, Washington, D. C., October 9 to 14, 1938. Cloth. Pp. 447, illustrated. Omaha: Douglas Printing Company, 1939.

Hypertension and Nephritis. By Arthur M. Fishberg, M. D., Associate in Medicine, Mount Sinai Hospital, New York City. Fourth Edition, Thoroughly Revised. Cloth. Pp. 779, illustrated with 40 engravings and a colored plate. Price, $7.50. Philadelphia: Lea & Febiger, 1939.

Medical Entomology. With Special Reference to the Health and Well-being of Man and Animals. By William B. Herms, Professor of Parasitology in the University of California, Consulting Entomologist for the California State Board of Health, Honorary Member National Malaria Committee. Third Edition. Based on the book known as "Medical and Veterinary Entomology." Cloth. Pp. 582. Price, $5.50. New York: The Macmillan Company, 1939.

Rural Medicine. Proceedings of the Conference Held at Cooperstown, New York, October 7 and 8, 1938. Cloth. Pp. 268. Price, $3.50 postpaid. Springfield: Charles C. Thomas, 1939.

The Physiology and Pharmacology of the Pituitary Body. Volume II. By H. B. Van Dyke, Head of the Division of Pharmacology, Squibb Institute for Medical Research, New Brunswick, New Jersey, Honorary Professor of Physiology, Rutgers University, Formerly Professor of Pharmacology in the University of Chicago and in Peiping Union Medical College. Cloth. Pp. 402. Price, $4.50. Chicago: The University of Chicago Press, 1939.

The Clinical Diagnosis of Swellings. By C. E. Corrigan, B. A., M. D., F. R. C. S. (Eng.), Lecturer in Surgery, University of Manitoba, Assistant Surgeon and Director of Out-patient Department, St. Boniface Hospital. Cloth. Pp. 313. Price, $4.00. Baltimore: The Williams & Wilkins Company, 1939.

General Medicine. Gregg Medical Dictation Series. Volume 1. By Marie Zweegman Yates, Director Zweegman School for Medical Secretaries, San Francisco. Experimental Edition. Paper. Pp. 90. Price, $1.00. New York: The Gregg Publishing Company, 1939.

United States Naval Medical Bulletin. Vol. XXXVII, No. 2, April, 1939. For Information of the Medical Department of the Navy. Paper. Pp. 153. Price, 25 cents. Washington: United States Government Printing Office, 1939.

Transactions of the Western Branch Society of the American Urological Association. Volume VII. Paper. Pp. 145. Printed in United States of America.

Tuberculosis and Appendicitis.—Eight more cases of tuberculous appendicitis were added recently to the report of the 151 already in the literature prior to May, 1937. The clinical course of the disease tends to chronicity, with recurrent attacks usually milder than the pyogenic types of appendicitis. Earlier recognition and early operation are urged.—Card, T. A., *California and Western Medicine*, 1939, 50.

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Leriche: The Surgery of Pain	6.50
Witherspoon: Clinical Pathological Gynecology	6.50

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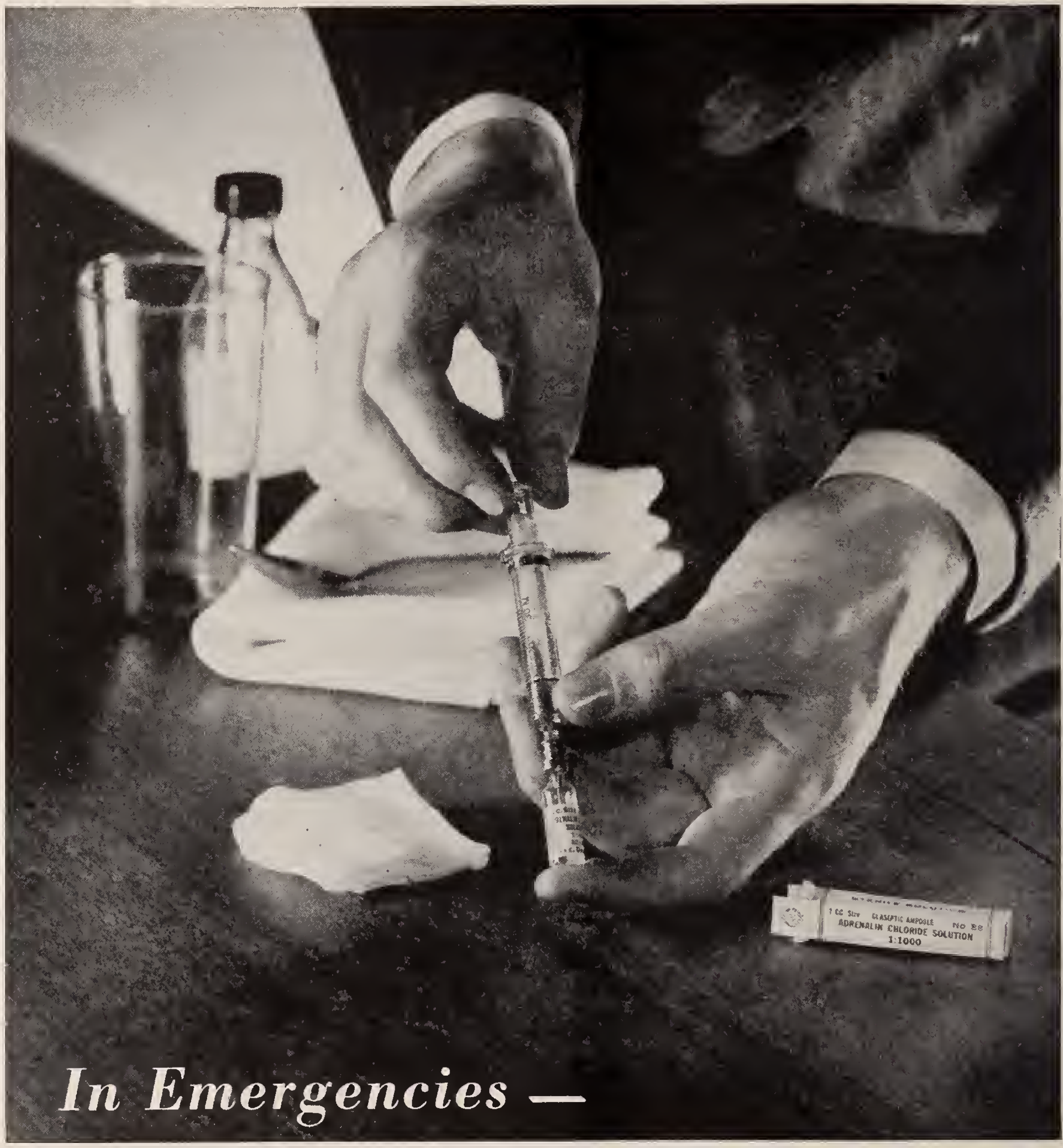
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Every part of the course will be preceded by a thorough foundation of the anatomy. Opportunity will be given to have demonstrations of operations on the living.

The privilege will be given to perform certain minor operations and have demonstrations in the various clinics. The dissections and the technic of the operations will be done by the students themselves.

Fee—$15 per month

Applicants must be graduates of schools approved by the State Board of Medical Examiners

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MEDICAL DIRECTORS, PASADENA, CALIFORNIA

TWENTY-FIVE YEARS AGO

(Continued from Text Page 464)

and energy of its president, Doctor Peers, who got together a splendid program for the whole of Wednesday; a program of sufficient interest to fill the room completely during nearly all of the various sessions and to hold the interest and attention of the audience present. . . .

From an Original Article on "Address of the President at the Forty-Fourth Annual Meeting of the Medical Society of the State of California—Santa Barbara, April 14. 1914," by Fitch C. E. Mattison, M.D., President.— . . . Social and industrial insurance claim a large share of the public attention at present, and it is but fair to assume that in all lines of industries that the cost of production should include in such costs certain fixed charges to insure those engaged in such industries against accident, sickness, and death. . . .

The National Insurance Act of Great Britain was first introduced into the House of Commons after a period, it is said, of two and a half years of study and preparation by its author, Honorable Lloyd George, Chancellor of the Exchequer, on May 4, 1911. The Act includes in its scope some fifteen million people from the age of sixteen to sixty-five of both sexes, whose incomes do not exceed $800 per annum. . . .

The commercialization of medical and surgical services by some of the casualty companies by offering fees approximating 25 to 30 per cent less than the fee tables adopted by the Industrial Commission, should not be permitted by members of the State Medical Society. . . .

From "Report of the Secretary and Editor."—Membership.—At the close of the year 1913, there were 2,396 members; at the close of 1912, there were 2,278 members on the roll; during 1913, thirty-four members died; thus, it is evident that the membership had 152 accessions during the year. The present plan of requiring all membership reports to be sent in early—before March 1—has worked admirably, and this year, up to April 1, something over 2,340 members have been reported and paid for and additional names are being sent in all the time. By the end of the year the membership will be at least as large as last year, in spite of the fact that the assessment is $6 this year as against $4 in previous years. . . .

In General.—The general tone of the Society was never better or more promising than at the present time; it seems to have come to the appreciation of an overwhelming majority of our membership that their Society is really doing something for them and is a power in certain ways. Doubtless this is largely due to the work of our legal department in medical defense. . . .

From "Twelfth Annual Report of the Council."—To the President and Members of the House of Delegates: . . .

Medical Defense.—The number of demands, threatening letters, threats of suits and suits actually filed, increased in 1913 over the large number in 1912. There is every reason to believe that the accident insurance law, which went into effect on January 1, 1913, and which will be referred to later, will cause a marked increase in such suits. The law prevents the bringing of a suit against the employer and consequently many cheap lawyers will be deprived of the pleasure of bringing such "contingent" suits. It does not prevent an action against the doctor, however,

(Continued on Next Page)

When Steers Had Long Horns

THE medicinal value of the glands of internal secretion was not recognized.

But times have changed, as well as cattle. Now, the therapeutic value of certain gland products is definitely established and each year adds to our knowledge in this important field of therapeutics.

To the physician prescribing gland products we urge specification of "Wilson," because it connotes a product made at the source of supply from fresh glands, processed promptly, with the aim of conserving maximum hormone activity, in a laboratory devoted exclusively to the endocrine field.

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It has been observed that low concentrations of sulfanilamide appear to be bactericidal in infections of the genitourinary tract if the urine is maintained at a pH of approximately 7.4.

May we suggest the use of CALSO before sulfanilamide administration to establish the desired urinary pH.

During sulfanilamide administration to maintain urinary pH and to offset possibility of supervening acidosis.

After sulfanilamide therapy to promote diuresis and assist in elimination of any residual drug.

CALSO is not a laxative and contains no sulphate

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TWENTY-FIVE YEARS AGO

(Continued from Preceding Page)

and so we may look for many such actions. It is said that in some states the number of suits for alleged malpractice increased as much as ten times, after similar industrial accident insurance laws went into effect. For this reason, as well as for others, it should be carefully considered by county units, as a matter of policy, whether it is not better to somewhat restrict membership and scrutinize carefully the professional standing and ability of applicants for membership. . . .

Industrial Accident Work.—We present to you herewith a plan for dealing with many of the problems which have arisen under the new industrial accident law, and a schedule of fees to apply to surgical work under that law, and we recommend that you adopt the plan and approve the schedule.

The general plan, which follows, was formulated at a number of conferences between Doctor Jones, representing the State Society, Doctor Kugeler, representing the San Francisco County Society, Doctor Parkinson, representing the Council and Sacramento, Doctor Gibbons of the Industrial Commission; and representatives of a number of insurance companies; it has been approved by the Adjustment Board, representing fifteen companies. The plan is the development and logical extension of the suggestions which have been made by Doctor Jones and published editorially in the last four issues of the JOURNAL. . . .

From "Fee Schedule."—These fees represent a minimum. Fees higher than schedule will be approved when warranted by extraordinary difficulties encountered by the surgeon.

Unusual cases and procedures not specified are entitled

(Continued on Page 18)

NASAL CONGESTION *Is Not Confined to Winter*

Rapid changes in temperature, the wearing of light apparel, and the recent innovation of artificial weather conditions in theaters, trains and office buildings appear to increase the incidence of nasal congestion in the summer months.

The so-called "summer catarrh," as well as rose fever, hay fever, and other conditions accompanied by a "running nose" and mouth breathing demand relief just as much as the head colds of winter.

Since so many of these nasal congestive disorders extend over a period of weeks or months, it is gratifying to know that the physician has at his command a vasoconstrictive agent which is active on repeated application, is both prompt and prolonged in action, and seldom displays undesirable side reactions.

NEO-SYNEPHRIN Hydrochloride

(laevo-alpha-hydroxy-beta-methyl-amino-3-hydroxyethylbenzene hydrochloride)

offers the following advantages in nasal decongestion:

—freedom from sting
—more sustained action than epinephrine or ephedrine
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SOLUTION . . . ¼% for dropper or spray, 1% for resistant cases (1-oz. bottle)
JELLY . . . . . ½% (in collapsible tubes with applicator)

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From this modest beginning the use of Stuart Hi-Pure has increased steadily. Now it is used by many leading hospitals in California, Washington, Oregon, and Arizona. These hospitals believe that a nitrous oxide of maximum practical purity (99% +) is a valuable aid to more even anesthesia. For complete clinical data, address us at 211 Bay Street, San Francisco.

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TWENTY-FIVE YEARS AGO

(Continued from page 16)

to same fee as specified procedures of approximately equal magnitude.

Note.—Bills must be itemized, showing date of each visit, dressing or operation, and charge for same.

The (name of company) is fully aware of the difficulties and inequalities of an inelastic fee schedule for surgical service. The schedule here presented is designed for use in connection with medical services rendered an individual with an average earning capacity of $1,000 per annum. To this class belongs the bulk of citizens which the Boynton Act is intended to protect and relieve. . . .

From "Minutes of the House of Delegates at the Forty-Fourth Annual Meeting, Santa Barbara, April 14, 15, 16, 1914."—First Session: Tuesday, April 14, 1914. The house was called to order at 8:30 p. m. by the president, F. C. E. Mattison.

The roll call disclosed the presence of fifty-one delegates, and the President announced a quorum and the house in session and ready for business.

* * *

Reference Committee.—The President announced the appointment of the usual Reference Committee on New Business as follows: George H. Kress, Los Angeles; Rene Bine, San Francisco; George A. Hare, Fresno.

The report of the Secretary was then read and referred to the Reference Committee. . . .

* * *

Medical Defense.—The following communication from the chief counsel of the State Society, which accompanied his voluminous report, was then read by the Secretary and referred to the same committee:

"San Francisco, Cal.,
April 11, 1914.

To the Medical Society of the State of California, San Francisco, California:

Gentlemen:—In connection with my report as to the malpractice suits during the year 1913, I have to advise you as follows:

Twenty-three cases for malpractice have been commenced in various parts of the State, as shown by my report and Mr. Morrow's report. In more than twenty cases, litigation was threatened, but no action was brought.

I believe that the widespread knowledge of the defense accorded free of charge by the Medical Society to all doctors in good standing, contributes very largely to diminishing the cases that are actually brought, when so many threats are made. I think that many more cases are never heard of because of the medical defense.

All lawyers know that they cannot settle with the doctors for the costs of a trial, and the attorneys' fees the doctor would have to pay, and this deters a certain class of attorneys from commencing these suits.

The increase in suits, and threatened suits, has been very marked, not only in California but, as I am informed, in other states in the Union. . . .

These good offices are freely tendered, at the expense of time and trouble, and this assistance given in thorough

(Continued on Page 20)

WHY
THE EMULSION...
Petrolagar
FOR CONSTIPATION

#3

Does not coat intestinal mucosa. Petrolagar is an aqueous suspension of mineral oil—oil in water emulsion.

1. Petrolagar is more palatable. Easier to take by patients with aversion to plain oil—may be thinned by dilution.
2. Miscible in aqueous solutions. Mixes with gastro-intestinal contents to form a homogeneous mass.
4. No accumulation of oil in folds of mucosa.
5. Will not coat the feces with oily film.
6. Does not interfere with secretion or absorption.
7. Augments intestinal contents by supplying an unabsorbable fluid.
8. More even distribution and dissemination of oil with gastro-intestinal contents.
9. Assures a more normal fecal consistency.
10. Less likely to leak.
11. Provides comfortable bowel action.
12. Makes possible five types of Petrolagar to select from to meet the special needs of Bowel Management.

Petrolagar — Liquid petrolatum 65 cc. emulsified with 0.4 Gm. agar in a menstruum to make 100 cc.

Petrolagar

Petrolagar Laboratories, Inc. • 8134 McCormick Boulevard • Chicago, Illinois

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- The Hydropathic Department devoted to the treatment of general diseases excluding surgical and acute infectious cases. Special attention given functional and organic nervous diseases. A well equipped clinical laboratory and modern X-ray Department are in use for diagnosis.
- The Cottage Department (for mental patients) has its own facilities for hydropathic and other treatments. It consists of small cottages with homelike surroundings, permitting the segregation of patients in accordance with the type of psychosis. Also bungalows for individual patients, offering the highest class of accommodation with privacy and comfort.

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1. Climatic advantages not excelled in United States. Beautiful grounds and attractive surrounding country.
2. Indoor and outdoor gymnastics under the charge of an athletic director. An excellent Occupational Department.
3. A resident medical staff. A large and well trained nursing staff so that each patient is given careful individual attention.

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DOuglas 3824

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1624 Franklin Street
GLencourt 5989

TWENTY-FIVE YEARS AGO

(Continued from Page 18)

accord with the efforts of the Society assists materially at the trial. Yours very truly,

W. W. Kaufman,
Attorney for Medical Society of the State of California."

✓ ✓ ✓

New Business.—The following communication relating to advertising in the State Journal was read and referred to the same committee:

"535 North Dearborn Street
Chicago, April 10, 1914.

Dr. Philip Mills Jones, Secretary,
Care of Hotel Potter, Santa Barbara, Cal.

Dear Doctor:—If you have a minute can you see a chance during the convention to get a word to the delegates on 'Patronizing Advertisers'? If so, urge that all advertisements are guaranteed, clean and good.

Also ask readers when answering advertisements to use the coupon or key numbers, so your Journal will get credit for the inquiries. Very truly yours.

Coöperative Medical Advertising Bureau.
E. W. Mattson."

✓ ✓ ✓

The following preamble and resolutions were presented by the Secretary at the request of R. L. Wilbur, and were referred to the same committee:

WHEREAS, The Congress of the United States entrusted to the City of San Francisco and the State of California the task of holding a Universal Exposition of the Arts, Sciences and Industries of the world as a means of celebrating the completion of the Panama Canal, uniting the two great oceans and establishing new routes of commerce; and . . .

Resolved, That the Bureau of Conventions and Societies of the Exposition, in coöperation with the officers of the American Medical Association, the American Society of Tropical Medicine, the American Public Health Association and affiliated bodies, be urged to set aside a distinctive two weeks' period for meetings of the congress and organizing bodies, to the end that all members of the medical profession, at the expense of one trip to San Francisco, may attend meetings of the associations of which they are members, and also take part in the proceedings of the congress; be it further

Resolved, That telegrams be sent to the officers of these several organizations, inviting them to hold their 1915 meetings in San Francisco and arrange for the proposed Congress on Tropical Medicine and Hygiene; be it further

Resolved, That copies of these resolutions be forwarded to the officers of the American Medical Association, the American Society of Tropical Medicine, the American Public Health Association and affiliated bodies.

Howard Morrow, A. W. Meyers, William Palmer Lucas, Herbert C. Moffitt, W. Ophüls, R. L. Wilbur, Frederick P. Gay (Chairman), Special Program Committee for Medical Societies, representing the American Association for the Advancement of Science. . . .

✓ ✓ ✓

The following resolutions were introduced by George H. Kress:

Resolved, By the House of Delegates of the Medical Society of the State of California at the forty-fourth annual session, that the Program Committee be enlarged by adding thereto, as ex-officio members, the secretaries of

(Continued on Page 22)

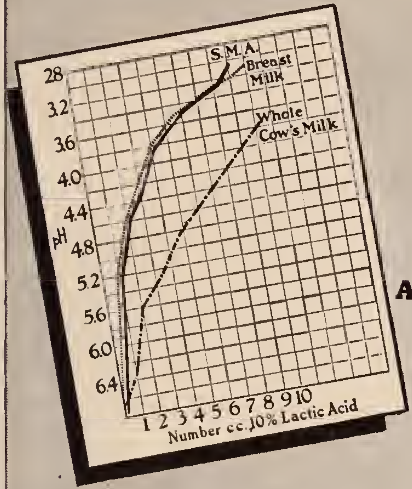
Why

S.M.A. FED INFANTS SHOW EXCELLENT NUTRITIONAL RESULTS

NOT ONLY IS THE ANALYSIS LIKE BREAST MILK

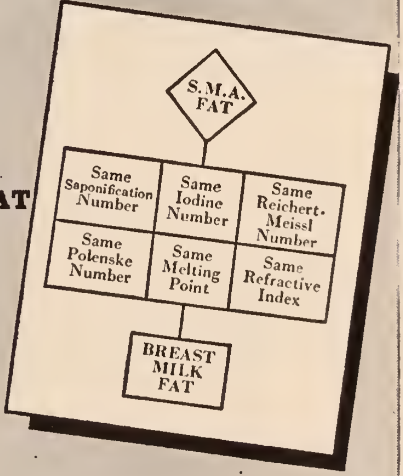
COMPARATIVE ANALYSIS OF S.M.A. AND BREAST MILK

Chemical and Physical Analysis	S.M.A.	Breast Milk
Fat..........	3.5-3.6%	3.59
Protein.......	1.3-1.4%	1.23-1.5
Carbohydrate	7.3-7.5%	7.57
Ash..........	0.25-0.30%	0.215-0.226
pH..........	6.8-7.0	6.97
Δ..........	0.56-0.61	0.56
Electrical Conductivity	0.0022-0.0024	0.0023
Specific Gravity.....	1.032	1.032
Caloric Value:		
—per 100 c. c.	68.0	68.0
—per ounce...	20.0	20.0



AND THE BUFFER LIKE BREAST MILK ....

BUT FAT OF S.M.A. IS LIKE BREAST MILK FAT



In Addition S.M.A. is an antirachitic and antispasmophilic food—has a Vitamin A, B, and D content in each feeding that is *constant every month of the year.* It is usually unnecessary to feed any vitamin supplements other than orange juice.

S.M.A. is a food for infants—derived from tuberculin tested cows' milk, the fat of which is replaced by animal and vegetable fats including biologically tested cod liver oil; with the addition of milk sugar and potassium chloride, altogether forming an antirachitic food. When diluted according to directions, it is ESSENTIALLY SIMILAR TO HUMAN MILK in percentages of protein, fat, carbohydrate and ash, in chemical constants of the fat and in physical properties.

SAMPLES FREE TO PHYSICIANS
(Please use Professional Stationery)

S.M.A. CORPORATION • 8100 McCORMICK BOULEVARD • CHICAGO, ILLINOIS

PROFESSIONAL PROTECTION

SINCE 1899
SPECIALIZED
SERVICE

A DOCTOR SAYS:

"I will never practice a day without the protection of your company."

THE
MEDICAL PROTECTIVE COMPANY
OF FORT WAYNE, INDIANA
WHEATON, ILLINOIS

The California Sanatorium

Belmont (San Mateo County), California
DR. MAX ROTHSCHILD, *Founder*

FOR THE TREATMENT OF TUBERCULOSIS

Completely Equipped ✓ *Excellent Cuisine*

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Address: BELMONT, Calif.
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Medical Placement Bureau
(AGENCY)
A California Organization Specializing in Trained Medical Personnel
83 McAllister St. » *San Francisco*
Phone MArket 6733
Helen J. Cowie, M.D.
Lillian F. Johnson, R.N.

TWENTY-FIVE YEARS AGO

(Continued from Page 20)

the different scientific sections of the Society. Referred to the same committee. . . .

* * *

Resolved, That the By-Laws of the Eye, Ear, Nose, and Throat Section as herewith presented be approved. Referred to the same committee.

Constitution

Article 1. Name. The name of this Section shall be the Eye, Ear, Nose, and Throat Section of the Medical Society of the State of California. . . .

* * *

Election of Officers

President.—Harry M. Sherman of San Francisco was nominated by Dudley Tait, and there being no other nominations, it was moved, seconded, and carried, that the nominations close and the Secretary cast the ballot of the House, which was done, and the President announced that Harry M. Sherman had been elected president for the ensuing year. . . .

Report of the Reference Committee . . .

Doctor Graves, in discussing Section 22 of the report, introduced the following as a substitute for the committee recommendation:

Resolved, That the Medical Society of the State of California favors an amendment to the present Industrial Insurance Act that will provide for the payment of a sum equal to the present indemnity plus the cost to the state of surgical attendance and hospital care. All money to be paid directly to the injured individual, who shall select his own medical attendant. No claims for indemnity will be honored unless accompanied by the certificate of the attending surgeon, who must be a duly licensed medical graduate of this state.

This resolution was declared out of order and deferred to new business.

After considerable discussion, a vote was taken on the adoption of Section 22 as presented (and as hereinafter published), and the motion to adopt was carried by a large majority.

Wallace I. Terry moved a reconsideration of the vote to adopt. Asked by the President if he had voted in favor of the passage of motion, he replied that he had. The President then put the motion to reconsider to the House, and it was defeated by a large majority.

PAN-PACIFIC SURGICAL CONGRESS
HONOLULU, HAWAII . . . SEPTEMBER 15 TO 28, 1939
A Scientific Program by International Authorities
Presiding, Dr. J. Hardie Neil, Auckland, New Zealand; Dr. Frederick Reichert, Chairman of Council, San Francisco; Dr. Edgar Gilcreest, Vice-President, San Francisco.
General Surgery, Surgical Pathology and Research; Traumatic, Orthopedic and Plastic Surgery; Obstetrics, Gynecology, Urology; Ophthalmology, Otolaryngology, Bronchoscopy; Roentgenology, Radiology; Neurosurgery, Thoracic Surgery, Anesthesia; Hospitals and Public Health; Round Table Discussions and Public Meetings; Surgical and Obstetrical Motion Pictures.

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It was then moved to return to the regular order of the recommendations in the report and proceed to their consideration. This was carried and the various sections adopted as presented and with minor modifications which were accepted as made and are included in the report as it appears below.

The report as a whole was then, on motion duly made, seconded and carried, adopted. . . .

From "Report of the Committee on Public Health."— . . . In this connection we are pleased to report that the United States Public Health Service has detailed Surgeon P. M. Carrington to make investigation of the tuberculosis problem in California.

The investigation has for its object the following:

1. To ascertain the extent and direction of the migration of tuberculous persons from other states into California south of San Francisco.
2. The effects of travel on tuberculous persons themselves.
3. The bearing of such migration on the health of other travelers and on employees of common carriers.
4. The conditions under which tuberculous persons live in localities resorted to for changes of climate, and the effects of these conditions on the progress of their disease.
5. The bearing of the presence of these persons on the health, social, and economic status of the communities to which they have migrated. . . .

From "Lassen-Plumas Counties."—On the evening of March 25, with the help of Doctor Bering, the Lassen-Plumas Counties Medical Society was organized, and adopted the Constitution and By-Laws prepared by the Committee on Organization of the American Medical Association. The following officers were elected: President, Dr. W. E. Dozier of Susanville; Vice-President, Dr. Ernest E. Wilson, Greenville; Secretary-Treasurer, Dr. R. W. T. Garner, Susanville; Delegate, Dr. E. S. Drucks, Susanville; Alternate, Dr. F. J. Davis, Westwood; Board of Censors, three-year term, Dr. F. D. Walsh, Susanville; two-year term, Dr. B. B. Bolton, Edgemont; one-year term, Dr. B. J. Lasswell, Loyalton. . . .

From an Original Article on "The Los Angeles Deaths from Intraspinal Neosalvarsan Injections," by Eugene S. May, M. D., Oakland.—The recent fatalities at Los Angeles following the intraspinal injection of neosalvarsan forcibly call to our attention the fact that intraspinal injection of toxic substances cannot be made without grave danger to life. In the Los Angeles cases, neosalvarsan (1-2-3 milligrams) was added to blood serum, the salvarsanized serum was then injected into the lumbar arachnoid space. Eight patients received the injection and died. One patient who lived two weeks received the first and largest dose of the salvarsanized serum. The important question arises: "What caused these deaths?" . . .

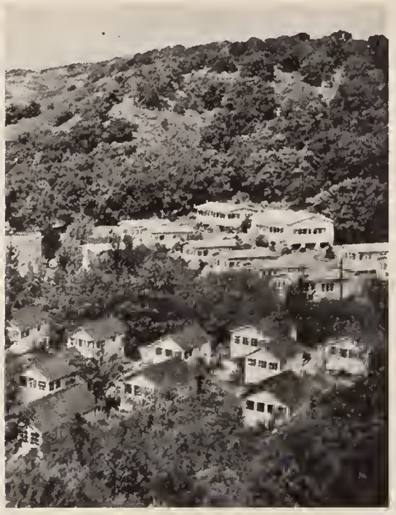
From "Society Reports."

Northern District Medical Society.—The Northern District Medical Society will hold a meeting at Marysville. June 9, 1914, 10:30 a. m., Liberty Hall. All members are requested to be present.

J. W. James, President.
F. C. Turner, Secretary.

(Continued on Next Page)

CANYON SANATORIUM
REDWOOD CITY, CALIFORNIA



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For the Treatment of Diseases of the Chest

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Nestled in the foothills, thirty miles from San Francisco, protected from the fog and wind, the Sanatorium partakes of a natural beauty that lends an atmosphere of contentment so conducive to the mental welfare of the patient.

EDWARD A. SCHAPER, M.D. *Medical Director*
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LEO ELOESSER, M.D. *Surgical Consultant*
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PHYSICIANS HEALTH ASSOCIATION

HOSPITAL
ACCIDENT
SICKNESS
INSURANCE

For ethical practitioners exclusively
(50,000 POLICIES IN FORCE)
Liberal Hospital Expense Coverage for $10.00 per Year

$5,000.00 ACCIDENTAL DEATH $25.00 weekly indemnity, accident and sickness	For $33.00 per year
$10,000.00 ACCIDENTAL DEATH $50.00 weekly indemnity, accident and sickness	For $66.00 per year
$15,000.00 ACCIDENTAL DEATH $75.00 weekly indemnity, accident and sickness	For $99.00 per year

37 years under the same management

$1,700,000 INVESTED ASSETS
$9,000,000 PAID FOR CLAIMS

$200,000 deposited with State of Nebraska for protection of our members.

Disability need not be incurred in line of duty—benefits from the beginning day of disability.

Send for applications, Doctor, to
400 FIRST NATIONAL BANK BUILDING • OMAHA, NEBRASKA

TWENTY-FIVE YEARS AGO

(Continued from Preceding Page)

Sacramento County.—Regular meeting of Sacramento Society for Medical Improvement, Hotel Sacramento, April 21, 1914.

President Dr. J. W. James in the chair. Minutes of previous meeting read. Dr. W. A. Beattie presented a case of polydactylism.

First paper of the evening: Trichinosis, by Dr. H. D. Barnard, describing two cases from Sacramento. Discussed by Doctors Parkinson, Williamson, and Twitchell.

Second paper: Hydatid Cyst, by Dr. J. R. Snyder, describing case developing in a Californian. Discussed by Doctors Barnard, Twitchell, G. C. Simmons, and Loizeaux.

Doctor Snyder was elected to membership.

Report of delegates to State Society made by Doctors Parkinson, Loiseaux, and Gundrum. Adjourned.

F. F. Gundrum, Secretary.

From "Personnel of the House of Delegates, Santa Barbara, April, 1914."—H. Bert Ellis. Henry Horn, G. H. Taubles, A. W. Hoisholt, George G. Reinle, L. P. Adams, T. C. Edwards, H. R. Oliver, Edw. R. Drucks, O. D. Hamlin, Rene Bine, H. E. Alderson, A. H. Mays, E. E. Brinkerhoff, R. R. Campbell, M. R. Gibbons, Dudley Tait, Kaspar Pischel, G. E. Tucker, H. B. A. Kugeler, C. G. Kenyon, H. A. L. Ryfkogel, J. L. Howard, R. E. Bering, B. T. Church, C. Van Zwalenburg, David Hadden, D. H. Moulton, L. R. Ryan, G. H. Kress, Margaret Smyth, C. B. Hare, A. B. Cooke, A. H. Kiger, H. G. Marxmiller, Carl H. Parker, P. K. Brown, W. B. Coffey, C. C. Browning, C. H. Whitman, A. F. Gillihan, John Carling, P. C. H. Pahl, C. P. Thomas, U. S. Abbott, P. B. Fry, F. F. Gundrum, F. B. Carpenter, H. W. Gibbons, R. L. Rigdon, G. A. Hare, P. Manson, R. T. Stratton, G. L. Cole, William W. Kerr, W. T. McArthur, E. S. Loizeaux, A. M. Henderson, B. J. Powell, C. W. Page, A. H. Dunn, David Powell, V. G. Clark, W. I. Terry, Howard Morrow, C. A. Dukes, A. H. Buteau, A. A. Alexander, John L. Dryer, George E. Ebright.

BOARD OF MEDICAL EXAMINERS

(Continued from Text Page 464)

by using the names of prominent persons on prescriptions but asserted he had not sold them or used them for commercial gain. . . ." (Los Angeles *Daily News*, May 5, 1939.)

"Everett H. King, forty-seven, who identified himself as the owner of the Basic Science Institute at 41 North Calaveras Street, early last evening was arrested on a warrant charging him with practicing medicine without a license. He pleaded guilty today in police court and was fined $200 and granted 360 days' probation. T. P. Hunter, special agent for the State Board of Medical Examiners, and Detective Sergeant J. A. Scott said King claimed to be a graduate chiropractor although he admitted not having take an examination from the State Board of Chiropractic Examiners. . . ." (Fresno *Bee and Republican*, April 21, 1939.)

"A special Iowa Senate investigative committee today reported 'immorality running rampant,' gay drinking parties and sex orgies at five institutions under the State Board of Control's supervision. In a written report, backed by piles

(Continued on Page 26)

"Vitamin B can be stored in the body to only a slight extent. It must be replenished by daily ingestion."*

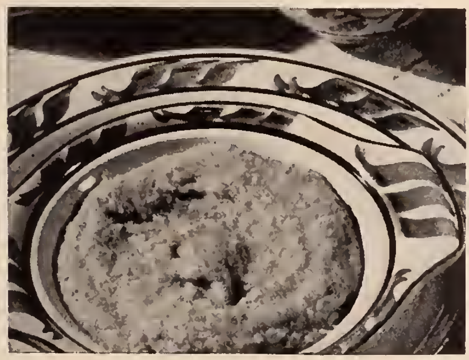
*Taub, Vitamin Manual

How daily servings of RALSTON WHEAT CEREAL protect against Vitamin B_1 deficiency

DOCTORS AGREE that infant diets must be strictly regulated. Unregulated diets often result in Vitamin B_1 deficiency, since each infant requires 50 International Units daily.* The diet prescribed must replenish this, day by day, to protect against deficiency.

**U. S. Dept. of Agriculture, Miscellaneous Pub. No. 275, page 22.*

ADULTS AND ADOLESCENTS normally require 200 International Units of Vitamin B_1 daily.* However, since most children, and many adults, ingest an *abnormal* amount of carbohydrates, their daily requirement is much higher. This is not available in American diets, which may contain little more than the minimum required to protect against actual *deficiency.*



RALSTON, THE HOT WHEAT CEREAL . . .

added to most diets, protects against Vitamin B_1 deficiency. Made from whole wheat, with only the coarsest bran removed, it is enriched with wheat germ, which contains 7 times as much Vitamin B_1 as whole cereal or eggs... 16 times as much as spinach... 40 times as much as milk. It supplies, *in one serving,* about ½ of the infant, and ¼ of the adult and adolescent daily requirement. Ralston also contains abundant energy producing elements, wheat proteins, minerals and carbohydrates.

Ralston cooks in 5 minutes — costs less than 1¢ a serving. Delicious in flavor, it is THE hot wheat cereal children really like to eat.

FREE SAMPLES! MAIL THIS COUPON TODAY

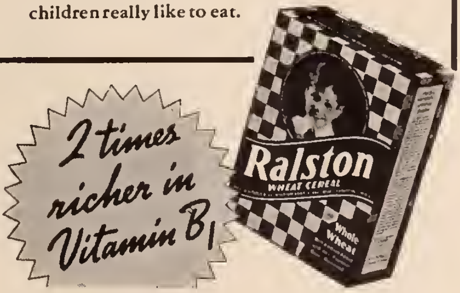
RALSTON PURINA COMPANY
Dept. CW, 3902 Checkerboard Square, St. Louis, Mo.

Please send me a copy of your Research Laboratory Report, and samples of Ralston, the wheat cereal which is "double rich" in vitamin B_1.

*Name*______________________________ *M. D.*

*Address*______________________________

(This offer limited to residents of United States)



If you could follow your ℞

through a Riggs laboratory you would quickly see how Riggs has earned its reputation for exactness.

No process of manufacture or inspection remains as a permanently standard routine—it functions only until an improved procedure is developed to replace it.

Your ℞ is always manufactured to today's standards—yesterday's methods have been discarded if a more exact procedure is available today.

▼

RIGGS OPTICAL COMPANY

Distributors of BAUSCH & LOMB PRODUCTS

ESTABLISHED IN EIGHTY-FIVE WESTERN CITIES

BOARD OF MEDICAL EXAMINERS

(Continued from Page 24)

of affidavits and testimony, the committee told of . . . an abortionist, convicted in California, on the staff of the State School of Feeble-minded at Glenwood. (He was dismissed since his exposure by the investigating committee.) . . ." (Press dispatch dated Des Moines, Iowa, April 11, printed Los Angeles *Herald-Express,* same date.)

"After claiming on the witness stand he could cure toothaches and grow fingernails, as well as cancer and tuberculosis, with his medicine, Vivogen, W. S. Yoemans was found guilty of false and fraudulent therapeutic claims by Judge E. P. Woods, Montebello Township Court. Yoemans, who manufactured the product, was fined $50 and ordered to cease selling Vivogen as a cure for any disease, according to Jonathan R. Kirkpatrick, Chief of the Division of Food and Drugs, Los Angeles County Health Department, who, with F. F. Unfred, Inspector in the Division of Food and Drugs of the State Health Department, declared that the asserted medicine was only a weak solution of lime water and had absolutely no curative value. This was the first case to be tried in connection with the drive being waged by Dr. J. L. Pomeroy, Los Angeles County Health Officer, against a number of distributors in Los Angeles County falsely claiming medicinal values in their products." (East Los Angeles *Belvedere Citizen,* April 21, 1939.)

"Miss Petrea Askov, twenty-five, former office aide and secretary to Dr. E. S. Cassady of San Pedro, today faced prospects of restoring $1,400 taken from office funds over a two and a half year period and appropriated to her own use while employed by the physician and surgeon. Under terms of a municipal court sentence, where she was convicted on three counts of petty theft, Miss Askov was given eighteen months in the county jail suspended, with the understanding that she is to repay $800 immediately and $25 per month for two years, during which time she will be on probation. . . ." (San Pedro *News-Pilot,* April 20, 1939.)

"Overlapping appointments by former Governor Merriam and Governor Olson to the State Board of Chiropractic Examiners were unscrambled by Attorney General Warren yesterday. On December 31, just before he left office, Merriam appointed an entire new board of five. His appointees included Dr. Roy G. Labachotte. On April 15 Governor Olson named Dr. Franklin Morris to succeed Doctor Labachotte. The latter refused to budge, insisting that he had been appointed for a three-year term. But yesterday, Warren advised the board that, whether Doctor Labachotte and Merriam knew it or not, Doctor Labachotte had merely been appointed to fill a term which expired February 10; that hence, Doctor Morris is the lawful member of the Board." (San Francisco *Chronicle,* April 28, 1939.)

"Mrs. Lena Mareck, fifty-four, charged with the illegal operation death last December of Mrs. Bertha Murray, Oakland housewife, was ordered released from the County Jail yesterday by Superior Judge Fritz. The court order came after a petition for the woman's release on a writ of habeas corpus, filed by Attorney Nate Coghlan, had been granted. Judge Fritz allowed the contentions of the writ, which asserted police failed to establish any public offense had been committed in their complaint against Mrs. Mareck. She was arrested last December following the death of the

Cosmetics and Your Patient's Morale

THE DOCTOR IS OF NECESSITY A STUDENT OF LIFE Each new patient presents a new study, a new problem. Psychology plays an important role in the course of treatment he prescribes With some patients he must be frank to a point of harshness, with others he must be gentle and coaxing The nature of the illness and, more particularly, the nature of the patient determine his attitude He knows from experience the value of bolstering his patient's morale As a student of psychology he knows that few things are more depressing to a woman than the fear that she is losing her charm, that when she no longer cares how she looks the chances are she has lost touch with a vital interest in life. And because he appreciates the importance of a sensible interest in personal appearance he quite rightly encourages his patients to look their best at all times. FINE COSMETICS appeal to that interest That is why they deserve to be recommended by doctors who are, after all, greatly concerned with their patient's morale.

LUZIER'S, INC., MAKERS OF FINE COSMETICS & PERFUMES

KANSAS CITY, MO.

21-year-old Mrs. Murray in an Oakland hospital. Police charged the young woman died after an illegal operation. (San Francisco *Chronicle*, April 11, 1939.)

"Dr. Donaciano Trevino, 64-year-old San Bernardino physician, was arraigned yesterday by L. M. Cox, United States Commissioner, on a charge of conspiracy to violate the Federal Narcotics Act. Doctor Trevino was arrested by David E. Hayden, U. S. Marshal. His arrest followed that of three women and one man, who were taken into custody earlier in the week on a charge of possession of narcotics. After arraignment Doctor Trevino was bound over to the Federal Court in Los Angeles for trial. He is being held in the County Jail in default of $1,000 bail." (San Bernardino *Sun*, March 12, 1939.)

"William A. Van Buren, fifty-three, 1240 San Mateo Avenue, Menlo Park, was arrested at his home yesterday afternoon on a San Francisco bench warrant charging him with violation of probation in connection with a 1939 charge of practicing medicine without a license. According to the arresting officer. T. P. Hunter, representing the State Board of Medical Examiners, Van Buren operated an advertised medical clinic at 702 Market Street, San Francisco. He pleaded guilty in November of last year. He was given a suspended jail sentence and ordered to pay a $200 fine in $35 monthly installments. Hunter said Van Buren was $50 behind in payments and that he failed to remove the advertising signs from his 'clinic'." (Redwood City *Tribune*, April 25, 1939.) (Previous entry September, 1938.)

"The appellate division of the Supreme Court of New York handed down a decision on January 11 upholding the refusal of the Board of Regents of the University of the State of New York to endorse the Italian license or diploma to practice medicine of Dr. Gustave G. E. DeLuca. The Board refused to endorse the license on the ground that there is great uncertainty as to whether the standards of the European institutions today are comparable with what they were when the law was enacted, which gives the Commissioner and the Board of Regents authority to endorse foreign licenses without examination. The Board offered the petitioner in this case the opportunity to take the licensing examinations." (*The Diplomate*, April, 1939.)

In an article published in *Medical Economics*, May, 1939, headed "The Refugees Dig In," comment is made on the problem of the foreign physician, which confronts the various states. "New York is no less concerned with the seriousness of its refugee doctor problem. Medical Society officials there point with alarm to the fact that native licensees for the year ending June 30, 1938, were outnumbered 556 to 419 by foreigners. Meanwhile the Department of Education reports that the total number of applications for its next medical examination will reach an all-time high. New York physicians find some solace in the Appellate Division's defense of the Board of Regents' right to reject foreigners seeking licenses by endorsement. Reversing an order of Supreme Court Justice Sidney F. Foster, the court has denied licenses to aliens Paul Erlanger and Julius Levi. Although they failed the examinations, the latter insisted they were entitled to licenses anyway. Reminding them that the standard of German medical schools is below that in New York, Justice Christopher J. Heffernan commented:

" 'The state has the right to demand that those who seek to practice medicine shall pass a satisfactory examination as evidence of skill and competence. Such a requirement is neither unreasonable nor discriminatory.'

(Continued on Next Page)

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BOARD OF MEDICAL EXAMINERS

(Continued from Preceding Page)

"Meanwhile, New York Assemblyman L. A. Lawrence has introduced a bill requiring citizenship for practice. A similar proposal is before the New Jersey legislature." Records indicate Austria specifically demands citizenship for medical license. Germany, France and Switzerland demand of foreigners that candidate's entire education, medical, premedical and secondary, be obtained in their own schools, thus effectively shutting out citizens of the United States who have received any part of their education outside respectively of these countries.

Police reports indicate that James T. Murray, M. D., was arrested in Los Angeles, April 12, 1939, as an alleged narcotic addict. (Previous entries, December, 1930.)

How to Prevent Tooth Decay*

What to Do

Eat Proper Foods.

Select nutritious foods with well-balanced mineral and vitamin content.

Drink a glass of milk with every meal.

Eat vegetables and fruits (cooked and raw), fruit and vegetable juices, meat, fowl, fish, eggs, cheese, whole-grain bread, butter, and any other special items your physician has advised.

Get your sweets from raw sugar, dates, figs, honey, fruit juices.

Select some of the coarser foods at each meal to strengthen the jaws and aid in the natural cleansing and exercising of the teeth.

Drink enough water.

Chew your food thoroughly.

Brush the Teeth Twice a Day.

Brush up and down—the way teeth grow. Brush in all directions to cleanse the grooves on the grinding surfaces.

Dedicate at least five or ten minutes out of the twenty-four hours to this important activity.

Equal parts of table salt, soda, and powdered borax make a good tooth powder. If flavoring and sweetening are desired, add a little oil of peppermint or menthol and saccharine.

If you prefer a prepared dentifrice, see that the seal of the Council on Dental Therapeutics of the American Dental Association appears on the package.

The brushing, and not the powder or paste, is what cleans the teeth.

Look in the mirror to see that the brushing has been thorough. Have sufficient light so that you may see well.

Rinse the mouth well with warm water to flush out all loosened débris and plaques.

Use a medicinal mouth wash only on the dentist's recommendation.

Be suspicious of dark spots on the surfaces or in the grooves of the teeth.

Be suspicious of chalky spots on the teeth.

Be suspicious of too red or too white an appearance of the gums.

Check up on other members of the family, especially the children, on the condition of the teeth and gums.

Consult a dentist (of sound ethical standing and good repute).

At least every six months (after seeing your dentist, mark your calendar ahead so that you won't forget when your next appointment is due).

(Continued on Page 30)

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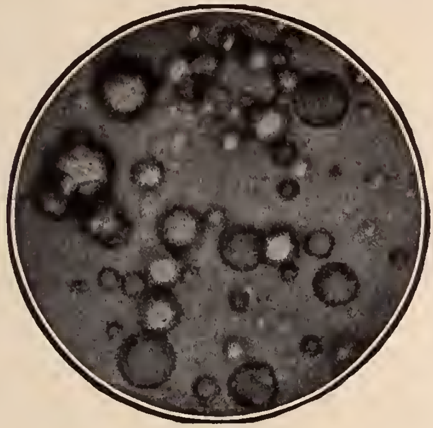
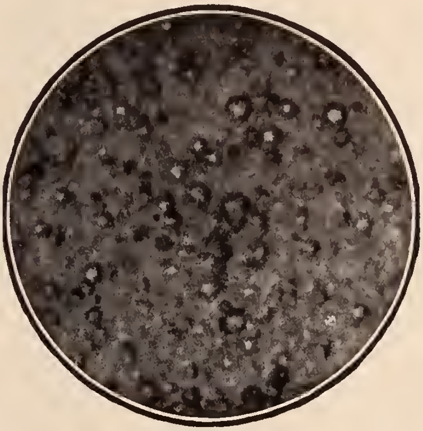
* By Verne L. G. Wilt, D.D.S.

More Easily Tolerated



Cod Liver Oil Concentrate Globules and Butter Fat Globules . . . before Homogenization



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[1] *Journal AMA 111:703 (August 20, 1938)*

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Bequest Forms: Unto the California Medical Association*

FORM OF CLAUSE OF WILL PROVIDING FOR CASH BEQUEST

I hereby give and bequeath unto Trustees Of The California Medical Association, a nonprofit corporation of California, the sum of $——— to be known as the ——— Gift, to be used and expended by said corporation for scientific, educational, or hospital purposes.

* * *

FORM OF CLAUSE OF WILL PROVIDING FOR CASH BEQUEST

I give and bequeath unto Trustees Of The California Medical Association, a nonprofit corporation of California, the sum of $———, to be held as a fund, to be known as the [here insert name desired] Fund, the principal whereof shall from time to time be invested to the best advantage compatible with safety, and the income whereof shall be used and applied for scientific, educational, or hospital purposes.

* * *

FORM OF CLAUSE OF WILL PROVIDING FOR BEQUEST OF PERSONAL PROPERTY

I give and bequeath unto Trustees Of The California Medical Association, a nonprofit corporation of California [here describe the property], the same, or the proceeds thereof, to be held as a perpetual fund, to be known as the [here insert name desired] Fund, the income whereof shall be used and applied for scientific, educational, or hospital purposes. The said corporation shall have the power to sell said property and to invest and reinvest the proceeds arising from the sale thereof from time to time as it may deem advisable for the purpose of producing as large an income as may be compatible with safety.

* * *

FORM OF CLAUSE OF WILL PROVIDING FOR DEVISE OF REAL PROPERTY

I give and devise unto Trustees Of The California Medical Association, a nonprofit corporation of California, to aid and further its scientific, educational, and hospital purposes, and to be known as the ——— Gift, the following described real property situate in the County of ———, State of California, and more particularly described as follows, to wit:

* * *

FORM OF CLAUSE OF WILL PROVIDING FOR DEVISE OF REAL PROPERTY

I give and devise unto Trustees Of The California Medical Association, a nonprofit corporation of California [here describe the property], the same, or the proceeds thereof, to be held as a perpetual fund, to be known as the [here insert name desired] Fund, the income whereof shall be used for and applied to the support and maintenance of scientific, educational, or hospital purposes. The said corporation shall have the power to sell said property and to invest and reinvest the proceeds arising from the sale thereof from time to time as it may deem advisable for the purpose of producing as large an income as may be compatible with safety.

---

* These Bequest Forms were discussed editorially in CALIFORNIA AND WESTERN MEDICINE, for March, 1936, p. 145, and June, 1936, p. 460.

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(Continued from Page 28)

Also, at first sign of blemish on teeth; at first sign of pain or discomfort; for dental prophylaxis treatments (deposit removal and polishing).

For instructions as to when and how to correctly use dental floss and mouth wash (kinds of mouth wash).

To have tiny breaks and cavities in the enamel of teeth filled at once, even if only with a temporary filling. Have permanent work done as soon as possible.

To have frequent (at least every two or three years) x-ray examinations made.

The dentist may then see the condition, not only of the teeth and other tissues, but also the condition of the previously inserted fillings and restorations.

Children's crooked teeth should be straightened while they are young enough for this kind of treatment.

WHAT TO AVOID

The danger of becoming accustomed to an unclean mouth and offensive breath.

Brushing the teeth laterally (since this wears grooves and notches at the necks of the teeth).

Harmful dentifrices and mouth washes.

Dental patent medicines and tooth bleaches.

Biting hard substances, thread, fingernails; cracking nuts; opening containers with teeth, etc.

Toothpicks; pencils in mouth, pins, etc.

Leaning weight of the head on hands or sleeping on hands or arms (since this pressure causes crooked teeth).

Too much cooked cereal (especially in the children's diet).

Carbonated beverages, candy, tobacco.

Rapid change of excessive heat and cold (*i. e.*, hot coffee and ice cream).

Constipation.

Diseased tonsils and adenoids.

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In the foothills of the Sierra Madre Mountains, thirty-five miles from the ocean. Surrounded by beautiful gardens.

Close medical supervision. Aside from tuberculosis, special attention is given to asthma, bronchiectasis, lung abscess and kindred diseases.

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Do not waste time worrying about it; do something about it.

"Be true to your teeth and they will not be false to you."

Erysipelas Mortality Rate Reduced by Sulfanilamide. The death rate from erysipelas has been greatly reduced by the use of sulfanilamide in its treatment, John Nelson, M.D., Harvey Rinzler, M.D., New York, and M. P. Kelsey, M.D., Temple, Texas, state in *The Journal of the American Medical Association* for March 18.

In 406 cases of erysipelas treated at Bellevue Hospital, New York, during the winter of 1935-1936 with erysipelas antitoxin the death rate in adults was 9.2 and in children 37.5 per cent. From January to July, 1937, 344 patients with the disease were treated with sulfanilamide and the mortality in 313 adults was 1.44 per cent and in thirty-one children it was 12.9 per cent.

Erysipelas is a contagious disease, characterized by fever, chills, insufferable itching and burning, painful swelling and spreading patches of redness of the affected part or parts.

It is another of the many varieties or types of streptococcic infections which apparently are effectively treated by sulfanilamide.

Adverse reactions (nausea, cyanosis, dizziness, vomiting and jaundice) may occur with sulfanilamide treatment. However, these reactions should not prevent or prohibit its use, but it is readily seen that the drug should be given only by an experienced physician and that the patient with this disease should be hospitalized.

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Consultation is private—and entails no charge or obligation. We will gladly prepare an Audiogram for any patient for whom you request such service—showing his hearing range *without* and also the increased range *with* the CRYSTALIC ACOUSTICON. Both graphs will be plotted on the same chart, so you can judge for yourself the improved and corrected hearing accomplished.

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CALIFORNIA AND WESTERN MEDICINE

OFFICIAL JOURNAL OF THE CALIFORNIA MEDICAL ASSOCIATION

VOL. 50 JUNE, 1939 NO. 6

California and Western Medicine
Owned and Published by the
CALIFORNIA MEDICAL ASSOCIATION
Four Fifty Sutter, Room 2004, San Francisco, Phone DOuglas 0062

Address editorial, business and advertising communications to Dr. George H. Kress as per address above.

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Subscription prices, $5 ($6 for foreign countries); single copies, 50 cents.

Volumes begin with the first of January and the first of July. Subscriptions may commence at any time.

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Responsibility for Statements and Conclusions in Original Articles.—Authors are responsible for all statements, conclusions and methods of presenting their subjects. These may or may not be in harmony with the views of the editorial staff. It is aimed to permit authors to have as wide latitude as the general policy of the Journal and the demands on its space may permit. The right to reduce or reject any article is always reserved.

Contributions—Exclusive Publication.—Articles are accepted for publication on condition that they are contributed solely to this Journal. New copy must be sent to the editorial office not later than the fifteenth day of the month preceding the date of publication.

Contributions—Length of Articles: Extra Costs.—Original articles should not exceed three and one-half pages in length. Authors who wish articles of greater length printed must pay extra costs involved. Illustrations in excess of amount allowed by the Council are also extra.

Leaflet Regarding Rules of Publication.—CALIFORNIA AND WESTERN MEDICINE has prepared a leaflet explaining its rules regarding publication. This leaflet gives suggestions on the preparation of manuscripts and of illustrations. It is suggested that contributors to this Journal write to its office requesting a copy of this leaflet.

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EDITORIALS[†]

SIXTY-EIGHTH ANNUAL SESSION OF CALIFORNIA MEDICAL ASSOCIATION

Del Monte Annual Session of 1939.—Once again, the members of the California Medical Association have held an annual session, the sixty-eighth, replete with many gatherings and conferences on scientific and organization problems of more than usual importance. When one is called on to provide all the immediate and accessory needs for the various meetings of an annual session, the many activities of the working units in the State Association make a special impression. This, however, need not be a matter of surprise, since the California Medical Association has more than six thousand members; and also because, at its annual conventions, the medical work requires detailed provision for twelve well organized scientific sections, and also for activities depicted by the scientific exhibits presented by individual members. Related work of affiliated groups was portrayed at three well attended microscopic and x-ray conferences held on the Sunday preceding the session proper, under the auspices of the Cancer Commission. Of value also were the clinical conferences under the lead of the California Heart Association. And not to be forgotten are the technical or commercial exhibits.

In addition to the above expressions of scientific medicine, and of equal interest and importance, were those relating to organized medicine, as manifested in the meetings of the House of Delegates and Council, with the practically all-day sessions of its reference committees, before whom members appeared to discuss questions of policy. Of equal allure were the general meetings at which guest speakers and officers of the Association brought affairs of pertinent interest to the attention of the entire membership.

In surveying the proceedings of the last Del Monte session, therefore, it may be said that recent years, marked as they have been in medical circles by marvelous advances in scientific knowledge, and also by increasing complexity and unrest in economic and social welfare matters, have added increasing responsibilities for California Medical Association members. Our Society, itself the outward or manifest expression of the organized physicians of the State, brought into being to promote the standards of public health and of medical practice, in these latter years has therefore no other recourse—whether it wishes or not—than to try to solve the problems which a rapidly changing civilization has brought to the fore and thrust upon it.

[†] Editorials on subjects of scientific and clinical interest, contributed by members of the California Medical Association, are printed in the Editorial Comment column which follows.

* * *

Special Features of the Recent Session.—Laying aside, now, these general reflections on trends in scientific and organized medicine, it may be in order to comment briefly on other phases of the recent annual session. The attendance was the largest ever recorded at Del Monte, and the scientific, organization, and social features all measured up to the best standards of former years. In spite of the hard times, the technical or commercial exhibits brought in the largest financial return yet registered for the Association. The dinner to Retiring President Roblee was marked by a peak attendance in the Hotel Del Monte dining room, with almost nine hundred places occupied. The Woman's Auxiliary, also, held its well attended meetings at the beautiful Del Monte Lodge. Everywhere, in fact, expression was given concerning the value of the 1939 session; and to all who lent aid in the arrangements, thanks are again tendered. The official proceedings may be gleaned by a perusal of the minutes of the House of Delegates and Council.*

* * *

Good Wishes to Newly Elected Officers.—To the newly elected officers, greetings and best wishes for successful terms are extended by the members of the Association.

Dr. Harry H. Wilson of Los Angeles is the recipient of the great honor, that of being President-Elect of the California Medical Association, his career of service to scientific and organized medicine already covering many years of loyal and efficient endeavor in movements designed to advance the profession's best interests. His broad general training will make him a valuable executive in times such as the present; and, with other officers who were elected, he may be assured of everyone's whole-hearted support.

At the close of the Wednesday evening meeting of the House of Delegates, Dr. William W. Roblee of Riverside laid aside the responsibilities of the presidential office to welcome as his successor his 1895 classmate of Cooper Medical College, Dr. Charles A. Dukes of Oakland. To Doctor Dukes, also, is given the pledge of generous coöperation in the arduous work ahead.

Medicine in California may be faced, in days to come, with many serious problems; but with just causes, clear thinking, loyal support and keen leadership, it need have little fear concerning the future, remembering, however, that at the present time, as never before, a generous and united support is necessary for the successful advancement and attainment of policies decided upon.

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* See pages 427 and 440.

PROPOSED COMPULSORY HEALTH LAW FOR CALIFORNIA: A.B. 2172

A. B. 2172 Fails of Passage in the Assembly: However, a Special Election Is in the Offing.—Press dispatches, of which several are given space in this issue,* indicate that Assembly Bill 2172, providing for a compulsory, capitation health insurance statute, will fail of passage in the present Legislature, which body may adjourn before this June issue of the OFFICIAL JOURNAL is placed in the mails. For such a nonenactment, members of the medical profession in California may heave a sigh of relief, temporary though that ease may be. For, if the prognostications of the leaders among the proponents of such legislation may be accepted, it is more than probable that a compulsory health bill will be on the state election ballot of November, 1940, as an initiative measure.

If Governor Olson calls a special election within the next several months (and, it is reported, he so intends, to permit citizens to again vote on the "$30 every Thursday" initiative), and if he includes in that call a compulsory health insurance law, it will then be necessary for the physicians of California to gird themselves for immediate battle on the issue.

* * *

Attitude of the Press.—The seriousness of the problem is one of the reasons so much space has been given for "Press Clippings" in recent numbers of CALIFORNIA AND WESTERN MEDICINE; since it must be evident that, in a battle against a law that would have such a devastating effect upon medical practice and public health standards, it is most important that every member of the California Medical Association should have had the opportunity to acquaint himself as fully as possible not only with the major facts and principles involved, but also with the attitude of fellow citizens as reflected in the daily newspapers. The press dispatches in the present issue are of a hopeful nature, so far as immediate legislative action is concerned; but they also mention the imminence of the forthcoming initiative struggle which will call for united and whole-hearted action, both individual and collective, and this to be given without stint. There will be required, in addition, the expenditure of considerable sums to provide the educational literature at once needed in such a campaign. If, therefore, Governor Olson includes compulsory health legislation in the special session he has stated he would convene, members of the California Medical Association may expect to be called upon for an expression of strenuous civic activity such as they have never yet been requested to give.

* * *

Recent Article by Mr. Chester Rowell.—Attention has been directed to the "press clipping" pages, in part because comments will here be made concerning Editor Chester Rowell's syndicated article of May 20, which has been given place, on page 454.

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* See page 454.

It is to be hoped that every reader of California and Western Medicine will take the time to peruse what Mr. Rowell recently wrote, particularly since he is the chairman of Governor Olson's Compulsory Health Committee, and presumably speaks with authority on the plans of the Administration, and also of the Committee and the other proponents of a compulsory system for California.

Having been present at speeches made by Mr. Rowell before the Commonwealth Club, having read many of his articles on the subject, having heard him and his supporters at the April 19 meeting in the Assembly Chamber at Sacramento, and listened also to the Administration's spokesmen when the "41 against" and "33 for" vote was taken in the Assembly on Tuesday, May 16, we confess that we were somewhat surprised on reading some of the statements in Mr. Rowell's article of May 20, referred to above.

Thus, the assertion:

"The only practical issue, therefore, was which way the vote of the people should be taken, and the Legislature has determined that it shall be by initiative."

Such a statement by Mr. Rowell must be construed as nothing else than one of editorial license. As a matter of fact, the Legislature made no commitment concerning an initiative, and did not vote on such a procedure. What took place was this: the Assembly indicated, by a vote of 41 to 33, that the compulsory health bill, as submitted in amended form on May 16, did not have its approval. What the proponents of the measure may have had in mind as regards an initiative was a matter not before the Assembly or Senate for vote.

The comment of Editor Rowell, in the paragraph immediately following the above and on the possible nature of "radical" and "conservative" initiatives, is of special interest, in that it seemingly indicates that these proponents are determined to force a vote on some kind of compulsory health law—whether good or bad, elastic or frozen, presumably not being in their minds of much importance. Remembering the expostulations heard from some of the advocates on the humanitarian needs of a compulsory capitation system, the "inhumanity" of forcing forthwith a possibly inelastic and harmful measure, with dire results to the very citizens whom they claim need more adequate medical care, certainly is indicative of inconsistency by such advocates. The attitude of some of these proponents seems to be that, having committed themselves to a certain type of compulsory health insurance, they are determined to bring the matter to final and immediate determination, without regard to whether there is urgent need therefor, or whether their much-amended and emasculated measure (for vote-getting purposes, supposedly), as by them expounded, will fulfill its exploited purposes. The thought comes to mind that there is here involved a certain amount of personal egotism by some of the propositional supporters. Certainly the issues at stake should transcend the will to be successful in the purely political battle.

Did space permit, one could continue with other exceptions to some of Mr. Rowell's statements. Members of the Association may well take the time to read the clipped excerpts in this issue, not only of his news, but of those of others. Their perusal will make for better presentation of the subject, when its various phases are taken up by physicians in the weeks to come, with both discerning friends and patients.

CALIFORNIA'S NEED FOR A BASIC SCIENCE LAW

California Has Three Examining Boards.—California is a State of "multiple examining boards." That is, it has legally authorized three different examining boards for healing art practitioners:

1. A board for nonsectarian practitioners holding the degree of Doctor of Medicine;
2. A board for the sectarian group known as Osteopaths; and
3. A board for another sectarian group catalogued as Chiropractors.

A third cultist group that has been knocking at the legislative doors for years is that whose members call themselves Naturopaths. This year, those belonging to this sect have put up a particularly strenuous fight and they may be counted upon again to present their statute in the 1941 Legislature asking for legal recognition.

In the present unsettled state of the public mind, common to lawmakers and the electorate, it is a question whether such a law, that would give necessary legal recognition by California to a third cultist group, could not, in the near future, go on to passage and enactment!

* * *

California Needs a Basic Science Law.—Which suggests, again, the great need of a Basic Science law for California—a subject that has been repeatedly commented upon and advocated in California and Western Medicine.

Such a law, to be of value in California, and to ensure application to existing healing art examining boards, and any that may come into being in the future, must be enacted by initiative vote of the people.

Several drafts of a Basic Science law, adapted to California's requirements, have been made, and have been submitted to the Council. The Council, unfortunately, at several state elections was not in position to authorize action, partly because of the expense involved—about thirty thousand dollars being needed for the educational campaign and to secure the more than 200,000 signatures with precinct allocations, identified by notary. Other factors, also, have operated to postpone action, as when, in the November, 1938, state election, the antivivisection initiative was deemed of such paramount importance that the Council was again obliged to forego submittal of the much-wanted initiative.

It has been shown that in the commonwealths in which such statutes have been enacted there is a better maintenance of healing art standards, and that therefore Basic Science laws make for real conservation of the public health. In California, most of the component county societies, and also the great majority of members, have expressed their approval of a law as proposed; and the 1940 state election ballot should include a Basic Science law among the initiative measures which will then be submitted to the people for vote. It is our belief that it would receive a most favorable vote of the electorate.

C. M. A. SPECIAL ASSESSMENT

Action of the House of Delegates.—Rapidly changing times are apt to create new and imperative needs. For the first time since the reorganization of the California Medical Association in 1902, its House of Delegates, in annual session assembled, has deemed it necessary to levy a midyear special assessment upon the members. From component county societies in different portions of the State, resolutions for such a purpose were presented by their respective delegations; and both purpose and scope of the contemplated "public health and welfare" work received earnest consideration before the reference committees and in the House.

The text of the resolutions adopted by the House of Delegates, and other informative material have been sent to every member of the Association, and in this issue of the Official Journal the minutes of our legislative bodies chronicle the action that was approved. Obedient to the direction of the supreme legislative body of the Association, the Council has issued instructions to carry through the mandate of the House.*

CONCERNING "INITIATIVE LAWS" ON THE CALIFORNIA MEDICAL HORIZON

Three Proposed Initiative Laws.—Whether they wish it or not, the next two years will place before the physicians of California proposed legislation, having to do with medical practice, which cannot be indifferently thrust aside. Every physician, then, who fails to meet his obligations merely places on the shoulders of his fellows an increased burden. This thought should be taken to heart by every medical licentiate in California.

What are these initiative problems?

1. The initiative for a revision of the Chiropractic Practice Act, which will be on the ballot of the special state election as early, perhaps, as next October.

2. The Compulsory Health Insurance Initiative. Such an initiative has been threatened by the proponents of a compulsory health insurance law, both before and since they failed to secure such legislation at Sacramento. If the special state election is not held until October, the advocates of a compulsory health insurance statute may be able to secure the necessary signatures for an initiative in time for placement on the ballot. Otherwise, it will probably appear on the 1940 state ballot.

3. Basic Science Initiative. The California Medical Association House of Delegates has instructed the Council of the Association to arrange for the placement of such an initiative on the state election ballot. The regular election in 1940 will precede the next legislative session in 1941. A Basic Science law could well wait, therefore, until November, 1940, for submittal to the electorate.

The above measures have not only a momentous relation to scientific medicine, but an even more intimate connection with the economic phases of private practice. No M.D. licentiate in California, therefore, but has an important stake in the legislation noted above.

Component county societies are urged to give these matters their very earnest attention. Bluntly phrased, it may be stated that, for the time being, these measures transcend discussions of scientific topics, no matter how intriguing the latter may be.

CALIFORNIA PHYSICIANS' SERVICE

Gratifying Registration Under C. P. S.—The large registration of members of the State Association for California Physicians' Service is a widespread evidence of the earnest desire of doctors of medicine to make possible adequate medical care for all social groups of the State; and in keeping with its known policies, California and Western Medicine has endeavored to promote this C. P. S. organization work by giving generous space to commendatory articles that have appeared in California newspapers, such press items usually reflecting, in many ways, the current thought of the more than six million human beings making up the population of the Golden State. To afford this extra space has naturally meant an increase in both the folios and the expense of their printing as part of the Official Journal. The issues at stake, however, are of such great importance that the additional costs seem negligible and justified.

The reports at the Del Monte annual session from officers of the California Physicians' Service and heard by the delegates representing the component county societies have no doubt, by this time, been transmitted by the delegates to their local colleagues, who will have learned that California Physicians' Service is moving forward as rapidly as the conventions of safety in procedure permit. Members may certainly rest assured that the officers of C. P. S. are alert to their grave responsibilities, and that full information will be sent to all physicians as soon as certain fundamental requirements are met.

C. M. A. WELCOMES A NEW COMPONENT UNIT

Inyo-Mono Counties Medical Society, the New Addition to the Fold.—Years have elapsed since a new county medical society has been welcomed into the fold of component units of the California Medical Association; this because the field for such extension work had practically been covered.

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* In this issue, see page 446, Item 11. For Official Notice, see page 426.

For some time, however, we have been hoping to see the counties of Inyo and Mono represented by a county medical society to better fulfill in their territory the needs of scientific and organized medicine; and this hope was realized when at Del Monte the Inyo-Mono Medical Society submitted its by-laws and made application for a charter, the petition being promptly and cordially granted by the House of Delegates. While recording this historical item, it may be observed that it is not without interest that these two counties, with little more than ten thousand population, are represented at Sacramento by their own state senator, while, in contrast, Los Angeles County, with almost three million in population, has in the California Senate of forty members, likewise only one representative. It may be added that the House of Delegates placed Inyo and Mono counties in the second or Los Angeles district, the roads from Los Angeles County being the best for travel.*

Good wishes are extended to this new unit which was formed through the foundation of a local medical society some months ago at a meeting sponsored by the State Association Secretary and Officers of the Los Angeles County Medical Association.

Other State Association and Component County Society News.—Additional news concerning the activities and work of the California Medical Association and its component county medical societies is printed in this issue, commencing on page 426.

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* See Resolution No. 10, on page 438.

Council Issues Revised Statement on Sulfanilamide.—Another revision of the statement of the Council on Pharmacy and Chemistry of the American Medical Association regarding the actions, uses, and dosage of sulfanilamide is published in the February 25 issue of *The Journal* of the Association. The Council says that its first statement on the drug appeared in *The Journal,* July 31, 1937, and a revised statement on October 30, 1937.

"The enormous amount of work which has been done with the use of this product warrants a second revision of the article," the Council says.

The more recent clinical evidence indicates, states the Council, that its action has been extended so that sulfanilamide becomes a still more useful drug with promise of value in some rare conditions. In treatment, particularly of streptococcic infections, results have been most striking in most patients, while in others, for reasons not yet known, the drug has not proved especially efficacious.

The Council again points out that the drug is one which should be used only under conditions which require caution and careful observation, particularly in view of side reactions. Because of its toxicity, patients to whom the drug is to be given should have daily attention by a physician. Many patients have shown some degree of development of a slate-gray type of cyanosis, first apparent in the lips and nail beds but afterward diffusing over the entire body. The exact nature of this cyanosis is unknown, but in the opinion of most observers it is not as serious a complication as it was once thought.

As the Council previously has warned, sulfanilamide should preferably be given alone, and not with other drugs unless specifically indicated.

EDITORIAL COMMENT†

PREVENTION OF SERUM SICKNESS

If confirmed, the studies of "inverse anaphylaxis" in man, currently reported by Voss and Hundt[1] of the Children's Clinic, Heidelberg, Germany, may lead to successful methods for the prevention of serum sickness, and may conceivably necessitate revisions of current theories of protein sensitivity.

The Heidelberg pediatrician drew blood from patients convalescent from serum sickness following routine administration of antidiphtheritic horse serum. From 1 to 10 cubic centimeters of the resultant convalescent human serum were injected intravenously in other children at various periods after therapeutic administration of diphtheria antitoxin. No allergic symptoms were noted if the convalescent serum was injected within twenty-four hours after administration of the diphtheria antitoxin. If, however, the convalescent serum injection was delayed till the third or fourth day, an "inverse anaphylactic reaction" was noted. This was shown by a generalized erythema, which usually disappeared within a few hours. If the convalescent serum injection was delayed till the eighth day, *i. e.,* till the end of the usual incubation period of spontaneous serum sickness, the inverse anaphylactic reaction was of "shock-like intensity."

Following these induced allergic reactions, the patients were completely desensitized, and did not react to subsequent injection with even massive doses of antidiphtheritic horse serum. Moreover, spontaneous serum sickness did not develop in these desensitized children after completion of the usual incubation period. Their findings suggest that intravenous injection of convalescent serum-sickness serum, given about the third day, might be a feasible method of preventing serum sickness. Whether or not earlier (symptom-free) injections would be equally effective was not determined.

From the theoretical point of view their studies of "inverse Prausnitz-Küster reaction" are even more suggestive. This "inverse Prausnitz-Küster reaction" was performed by injecting 0.1 cubic centimeter of dilute diphtheria antitoxin (or normal horse serum) subcutaneously in normal children. From eight to twelve hours later these children were given an intravenous injection with 1 to 5 cubic centimeters human convalescent serum-sickness serum. Within thirty minutes, marked edema and erythema developed in and around the area injected with horse proteins. The unsuspected result, however, was their observation that this "inverse Prausnitz-Küster reaction" is not specific for horse proteins. Control skin areas injected eight to twelve hours previously with ox or sheep proteins, reacted equally promptly and with equal intensity.

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† This department of CALIFORNIA AND WESTERN MEDICINE presents editorial comments by contributing members on items of medical progress, science and practice, and on topics from recent medical books or journals. An invitation is extended to all members of the California Medical Association to submit brief editorial discussions suitable for publication in this department. No presentation should be over five hundred words in length.

[1] Voss, A. E., and Hundt, O.: Ztschr. f. Immunitätsforsch., 94:281 (Nov.), 1938.

To explain these apparently illogical results, Voss and Hundt postulate a secondary relatively nonspecific "serum-sickness antigen," formed or liberated as a result of interaction between alien proteins and normal human tissues, with secondary antibodies formed against these hypothetical secondary antigens. This is a renaissance of a tentative theory of primary, secondary, and tertiary antigens and antibodies suggested, several years ago, to account for certain allergic phenomena.[2] That entirely new or "hybrid" specificities can be formed as a result of interactions between proteins of different animal species has been demonstrated by Zoet[3] of Stanford University Medical School. A simple method for the preparation of such "mixed" or "hybrid" proteins or "secondary antigens" has been recently perfected by European biochemists.[4]

Box 51.

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THE ADRENOGENITAL SYNDROME*

There seems to be an urgent need for a more rational evaluation of the adrenogenital syndrome. Clinical diagnosis and treatment is being handicapped by confusion as to the pathogenesis of this disease.

Various degrees of intersexuality are relatively common. Virilism characterized by hirsutism, obesity and ovarian dysfunction in the female, and feminization of the male has been widely, though none too clearly discussed.

Diagnosis of these sex-reversal states is being materially helped by sex hormone assays [1-4] and x-ray visualization of the adrenals,[5] so that tumor cases (*i. e.*, with positive x-ray and sex hormone assay evidence) may be readily segregated from the relatively very common benign functional or subclinical varieties of the adrenogenital syndrome.[6,7] Though the etiology of the anomaly be quite obscure, recent evidence promises to clarify the clinical evaluation of the disease.

Recent biologic observations clearly point to a congenital polyglandular dysfunction as the underlying basis for the adrenogenital syndrome, as well as for the majority of cases of intersexuality. However, there seems to be a universal failure to appreciate the essential polyglandular character of this disease, and the usual clinical approach is limited to the surgical exploration and occasional resection of what appears to be a hyperplastic adrenal or gonad (ovary and testicle). Surgery is justifiable when a tumor can be demonstrated, but certainly is illogical and unwarranted in those cases without the clinical evidence of tumor (as seen with the special x-ray and hormone studies).

Indications for surgical exploration have been based on rather loose clinical judgment. The hazardous adrenal surgery for the functional self-limited forms of the disease should be condemned. Surgical morbidity and mortality from adrenal shock may run very high.

From present evidence[8,9] the pituitary, adrenal, and gonad are all vitally involved not only in the development of normal sex patterns, but in the genesis of the adrenogenital syndrome. To emphasize the widespread pathologic physiology which characterizes the adreno-genital syndrome it may be well to point out that anomalous sex development arises from abnormal sexual differentiation, not only of the ovary, testicle and adrenal cortex, but also of the adenohypophysis. Pfeiffer[8] has demonstrated experimentally that the pituitary, like the gonad, is bipotential at first, and is capable of being differentiated as either male or female types, depending on whether a fully differentiated ovary or testis is present; after puberty the sex type is relatively stable, so that experimental efforts to change it have failed. All of this means that anomalous sex patterns arise from some abnormal development of the adreno-gonadal apparatus which, in turn, conditions adversely the pituitary sexual differentiation. Anomalous development is particularly apt to occur in the ovary because of a normal "masculine phase" in the sequence of female differentiation. Broster and Vines[9] point to this "element of instability" as the cause for the greater frequency of intersexuality in the female.

One may then speculate that if the normal embryologic transition from the brief ovarian masculinization to a fully differentiated female gonad should be retarded or impaired to any degree, so that the ovary remains partially masculinized, then the "sex typing" of the pituitary may likewise be defective. Future pituitary gonad-tropic physiology would, therefore, be partly masculine or intersexual in its function. If this concept of a polyglandular disorder be valid, then any therapeutic consideration must, obviously, include the adenohypophysis, as well as the adrenogonadal apparatus in the pathogenesis. From this standpoint the usual clinical aproach, whether it be medical or surgical, is certainly inadequate and in many respects futile.

To cope successfully with the subclinical adrenogenital syndrome, based on widespread functional pathology, remains a great therapeutic problem. But in the meantime let us refrain from ill-advised surgical attempts, unless a tumor of the adrenal or gonad can be clinically demonstrated.

1930 Wilshire Boulevard.

Samuel J. Glass,
Los Angeles.

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[2] Manwaring, W. H., Marino, H. D., McCleave, T. C., and Boone, T. H.: J. Immunol., 13:319, 1927.

[3] Zoet, August G.: Proc. Soc. Exp. Biol. and Med., 32: 1469, 1935.

[4] Tiselius, A., and Horsfall, F. L.: Jour. Exp. Med., 69:83, 1939.

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* Suggesting a more rational evaluation.

[1] Callow, R. K.: Lancet 1:435, 1938.

[2] Simpson, S. L., et al.: Endocrinology, 20:363, 1936.

[3] Frank, R. T.: Proc. Soc. Exp. Biol. & Med., 31:1204, 1934.

[4] Butler, G. C., and Marrian, G. F.: J. Biol. Chem., 119: 565, 1937.

[5] Cahill, G. F.: J. Urol., 34:238, 1935.

[6] Glass, S. J., and McKennon, B. J.: West. J. Surg., 45: 467, 1937.

[7] Glass, S. J., and Bergman, H. C.: Endocrinology, 23:625, 1938.

[8] Pfeiffer, C. A.: Am. J. Anat., 58:195-225, (January) 1936.

[9] Broster, Allen, Vines, Patterson, Greenwood, Marrian and Butler: The Adrenal Cortex and Intersexuality, Chapman & Hall, London, 1938.

ORIGINAL ARTICLES

DIAPHRAGMATIC HERNIA: RESULTS OF SURGICAL TREATMENT IN 210 CASES*

By Stuart W. Harrington, M. D.
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I

THE subject of the diagnosis and treatment of diaphragmatic hernia has received more consideration in recent years because its more frequent recognition has changed its status from a rare condition to one that is not infrequently encountered. However, I believe that this subject deserves more general interest and consideration than it is now given, since in many instances the diagnosis is not made until complications have occurred. This subject is of interest to the clinician because the diagnosis is of first importance, the symptoms are often complex and the condition frequently must be considered in the differential diagnosis of diseases of the upper part of the abdomen and lower part of the thorax. It is of interest to the roentgenologist because the roentgenologic recognition of diaphragmatic hernia is often the only means by which a definite diagnosis can be established clinically. The treatment is of primary concern to the surgeon as operative replacement of the herniated viscera, and repair of the abnormal opening in the diaphragm are the only treatments that promise complete relief of symptoms.

Diaphragmatic hernia occurs more commonly than is generally thought. A review of the records of The Mayo Clinic revealed that, from January 1, 1908 to December 31, 1938 inclusive, a diagnosis of diaphragmatic hernia was made roentgenologically or at operation in 514 cases. Of the 514 patients, 247 were males and 267 were females. The oldest patient was eighty-two years of age and the youngest patient was three months of age. The average age of the patients was 43.7 years. In the first case that was observed at the Clinic the hernia was of the esophageal hiatus type, and was discovered at operation in 1908. The first roentgenologic diagnosis of a diaphragmatic hernia at the Clinic was made in 1911. This hernia was of the traumatic type. The first roentgenologic diagnosis of an esophageal hiatus hernia at the Clinic was made in 1921.

The more frequent recognition of diaphragmatic hernias in recent years is exemplified by the fact that a review of the cases observed between January 1, 1908 and December 31, 1925 inclusive, revealed that a diagnosis of this type of hernia was made in only thirty cases observed at the Clinic. In fourteen of the thirty cases the patients were treated surgically. From January 1, 1926 to December 31, 1938 inclusive, 484 patients received a diagnosis of diaphragmatic hernia, of whom I operated on 210. This study, therefore, disclosed that sixteen times as many diaphragmatic hernias were recognized in the last thirteen years as had been recognized in the previous eighteen years. I believe that the condition is even more common than the present records indicate. I have examined the diaphragm in the course of other abdominal operations and occasionally have found a small hernia that had not been recognized clinically or roentgenologically before operation.

This more frequent recognition of the condition in the last two decades has been attributed primarily to the development in roentgenologic methods of diagnosis. The clinical study of cases of proved diaphragmatic hernia has established rather definite symptoms which have enabled the clinician to diagnose the condition or to suspect its presence and request a special roentgenologic examination. I do not believe that the entire credit for the more frequent recognition of this condition is due the roentgenologist. I believe that he must share this credit with the clinician. A greater proportion of the responsibility for the establishment of the correct diagnosis must rest on the clinician. He is the first to see a patient, and the subsequent course of the examination and the treatment depend on his interpretation of symptoms.

Recognition of a diaphragmatic hernia clinically is often difficult because of the complex symptoms, which simulate those of other organic disease of the abdomen and thorax. This, I believe, is one of the most important clinical considerations of diaphragmatic hernia. It is particularly true in cases in which the hernias are progressive and the symptoms vary, depending on the degree and type of herniation. In such cases several clinical diagnoses can be made because of the changing symptoms. The condition may be termed the "masquerader of the upper part of the abdomen," because the symptoms frequently simulate those of other diseases. A study of the 210 patients on whom I operated between January 1, 1926 and December 31, 1938 inclusive, disclosed that an average of more than three previous erroneous clinical diagnoses had been made before the correct diagnosis was established. The most common erroneous diagnoses, in order of frequency, were cholecystitis, cholelithiasis, gastric ulcer, duodenal ulcer, hyperacidity, secondary anemia, cardiac disease, cancer of the cardia, stricture of the esophagus, appendicitis, and intestinal obstruction. This was of particular surgical significance, because in twenty-three of these cases the patients had been operated upon previously for other conditions, without complete relief of symptoms, and were completely relieved following repair of the hernia. Of these twenty-three patients, thirteen had undergone cholecystectomy, four had undergone cholecystostomy, three had undergone appendectomy, two had undergone pyloroplasty, and one had been subjected to a gastro-enterostomy. Five of these patients—two who had been subjected to operation for duodenal ulcer and three who had undergone an operation for

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* From the Division of Surgery, The Mayo Clinic, Rochester, Minnesota.

Read before the meeting of the California Medical Association, Del Monte, May 1-4, 1939.

TABLE 1.—*Data in 210 Cases of Diaphragmatic Hernia in Which Operation Was Performed*

Site of Opening	Cases	Cause	Cases	Content of Hernia	Cases
Esophageal hiatus	153	Congenital (history of trauma, 12 cases)	153	Stomach (omentum) Stomach, omentum and spleen Stomach and colon	144 3 6
(Short esophagus type)	11	Congenital	11	Stomach only	11
Hiatus pleuroperitonealis	4	Congenital	4	Colon and small bowel Colon, small bowel, stomach and spleen	3 1
Absence posterior fourth left diaphragm	4	Congenital	4	Stomach, colon, small bowel and spleen Small bowel and colon	3 1
Foramen Morgagni	2	Congenital	2	Colon and omentum	2
Left diaphragm	35	Trauma (indirect injury, 25 cases; direct injury, 6 cases) Inflammatory necrosis, 4 cases	35	Stomach only Stomach and colon Stomach, colon and small bowel Stomach, colon and spleen Stomach, colon, spleen and small bowel Stomach, colon, small bowel and liver Stomach, colon, small bowel, spleen and liver	5 10 5 2 9 2 2
Right diaphragm	1	Trauma (direct)	1	Stomach, colon, small bowel, liver (gall bladder) and head of pancreas	1
Total	210		210		210

gall-stones—had obtained partial relief of symptoms but had continued to have distress from an unrecognized esophageal hiatus hernia. This again emphasizes the importance of examining the diaphragm in the course of all operations on the upper part of the abdomen, particularly when the clinical syndrome has not been typical, or when the operative findings elsewhere than about the diaphragm do not adequately explain the patient's symptoms.

CLASSIFICATION

The conditions that influence the symptoms of diaphragmatic hernia depend to some extent on the type of hernia, whether it is congenital or acquired, and whether or not trauma has been an etiologic factor.

From a clinical standpoint, the history of preceding injury is helpful in establishing the clinical diagnosis and in determining the type of hernia, the urgency of the condition and the prognosis when operative treatment is employed. Because of the clinical and surgical significance of trauma as an etiologic factor, I have suggested that diaphragmatic hernia should be classified in two main groups—nontraumatic and traumatic—and I have subdivided these according to the various types.

A nontraumatic diaphragmatic hernia may be congenital or acquired. If congenital, the hernia is attributable to embryologic deficiency and usually does not have a hernial sac. The most common sites of a congenital hernia, in the probable order of frequency of occurrence, are: (1) through the hiatus pleuroperitonealis (foramen of Bochdalek), (2) through the dome of the diaphragm, (3) through the esophageal hiatus, (4) through the foramen of Morgagni, and (5) through the gap left by partial absence of the diaphragm, which is usually in the posterior portion of the muscle.

If the hernia is acquired after birth, the sites of occurrence are: (1) through the esophageal hiatus, with a type having a hernial sac, (2) through the region of fusion of the anlage of the diaphragm, and (3) at sites named under the congenital type.

Traumatic diaphragmatic hernia may be caused by direct or indirect injury, or by inflammatory necrosis of the diaphragm.

In case of indirect injury of the diaphragm, the hernia may occur at any point, including points of embryologic fusion; but the most common sites are the dome and posterior half of the left part of the diaphragm, or it may occur in the right part of the diaphragm. It usually is the result of a severe, crushing injury and the hernia may or may not have a sac. When the hernia occurs through the esophageal opening there is a sac, but when it occurs through the leaf of the diaphragm there usually is no sac.

In case of direct injury of the diaphragm, the hernia may occur at any point and is usually the result of penetrating wounds, such as those inflicted by a gun or a knife.

Rupture of the diaphragm may be the result of inflammatory necrosis which, in turn, has been caused by a subdiaphragmatic abscess, or rupture may follow necrosis caused by drainage tubes introduced into empyema cavities. In these cases the opening usually is in the posterior part of the diaphragm and there is no hernial sac.

Table 1 shows the sites of the opening in the diaphragm, the probable cause, and the contents of the hernias in 210 cases in which I operated for diaphragmatic hernia.

In a general way the various types of diaphragmatic hernia can be divided clinically into two main classes, depending on the abdominal viscera which are involved. In the first class the stomach is the only abdominal viscus incorporated in the hernia; the hernia usually occurs through the esophageal hiatus. In the second class, the intestines, with or without the stomach and other abdominal viscera, are included in the hernia. These hernias are usually of traumatic origin and are caused by laceration of a normal diaphragm. They also may be of congenital origin and may result from structural deficiency of the diaphragm.

Esophageal hiatus hernia is the most common kind of hernia through the diaphragm that is found among adults. This type of hernia is slowly progressive and constitutes a sliding herniation of the stomach into the posterior mediastinum. It may push into either or both thoracic cavities, but does not enter the pleural cavity. The stomach is usually the only abdominal viscus involved in the hernia. This type of hernia may progress until the entire stomach is contained within the hernial sac, and the colon, omentum, and occasionally the spleen may also be drawn into the hernial sac.

SYMPTOMS

The symptoms of esophageal hiatus hernia may begin at birth or at any time in life. This kind of hernia produces more uniform symptoms than do hernias elsewhere in the diaphragm. The symptoms are those of intermittent, and usually progressive, incarceration and obstruction of the stomach. It is because of the progressive character of the hernias that the symptoms vary, depending on the amount of stomach that becomes incorporated in the hernia, the degree of interference with the diaphragm as well as the size of the hernial orifice, and the occurrence of associated complications such as traumatic ulcer and incarceration of the stomach. At first the symptoms may be mild in character and consist of mild distress in the lower part of the substernal region. This distress occurs while the patient is eating and it often produces a sensation of obstruction to food entering the stomach. It is often accompanied by pain, which is situated in the midline of the epigastrium to the shoulder, and is projected through to the back. The symptoms are more marked after the patient has eaten heavy meals and in many instances they are particularly noted at night. They are usually relieved by belching of gas or by vomiting. As more of the stomach becomes involved in the hernia, the symptoms become progressively more severe. The epigastric pain and distress are often severe enough to simulate gallbladder colic. If traumatic erosions have occurred, there is often an associated gastric hemorrhage which may be noted in the vomitus, but it more commonly is evidenced by the presence of occult blood in the stool. A marked secondary anemia is present in about 10 per cent of cases; this was one of the chief symptoms observed in the cases at the Clinic. In cases of this type the symptoms often simulate those of peptic ulcer so closely that the patient is given ulcer treatment. In cases in which the hernia is extensive, the pressure of the herniated stomach on the pericardium and the reflex nervous disturbance cause symptoms which simulate heart disease that is associated with palpitation, dyspnea and pain that extends to the shoulder and neck through the phrenic nerve.

In cases in which the hernia has been present for a long time, there may be marked ulceration in the lower end of the esophagus, which later causes a stenosis as a result of cicatricial contraction. Patients who have esophageal hiatus hernia, of which the predominating symptoms are those of esophageal obstruction, are of particular interest and require careful clinical study. The symptoms may be attributable to an entirely unassociated lesion of the lower part of the esophagus, such as cardiospasm, carcinoma or diverticulum, or they may be the result of ulceration or stricture of the esophagus that is caused by the hernia. Because of the possibility that there may be a lesion in the lower end of the esophagus, which is caused by or is unassociated with a hernia, I believe an esophagoscopic examination is advisable in all cases in which the presence of a diaphragmatic hernia is suspected.

The chief symptoms of esophageal hiatus hernia depend, to some extent, on the time in the course of the disease at which the patient is examined, on the rapidity with which the hernia has been produced, on the amount of fixation of stomach in the thorax, and on the amount of disturbed function of thoracic organs.

The symptoms of traumatic hernia or of nontraumatic, congenital types of hernia, in which only the stomach is involved in the hernia, are essentially the same as those described, but they are usually more severe and acute and do not last. Cases of this sort are relatively rare, because in these types of hernia the large and small bowel, as well as the stomach, spleen, and occasionally the liver, usually are involved in the hernia. There is no limiting sac, and the herniated abdominal viscera are in direct contact with the lung and pericardium. The condition in these cases may be more properly termed "evisceration of the abdominal organs into the pleural cavity" rather than a "true hernia."

In cases of traumatic hernia the symptoms progress very rapidly, are severe in character, and are attributable to the mechanical interference with function of the herniated viscera as well as to marked interference with function of the heart and lungs. The symptoms in these cases are even more severe than those in congenital types of hernia because of the sudden alteration of the intrathoracic pressure as well as the mechanical interference with the function of the organs involved. The most marked immediate symptoms are usually those of respiratory and circulatory embarrassment. Later, severe hemorrhage from the gastro-intestinal tract may occur as a result of incarceration or strangulation of the hollow viscera. If the patient survives the acute condition, the later symptoms depend on the viscera involved. The symptoms may consist of obstinate constipation, the occurrence of large quantities of gas in the colon, and attacks of partial or complete intestinal or gastric obstruction. The sudden onset of symptoms in cases of traumatic hernia usually is related directly to the injury, and there is no question as to the clinical diagnosis. Surgical treatment is demanded because of the danger of cardiac and respiratory failure or of intestinal strangulation.

The Mayo Clinic.

(To be continued)

CHRONIC ULCERATIVE COLITIS*

By ALFRED C. REED, M.D.
San Francisco

PART I

SEVERAL reasons have conjoined to lead investigators to consider that so-called idiopathic chronic ulcerative colitis might have a bacterial cause. Among these reasons may be noted the frequent occurrence of fever, the frequently observed precedence in time of an undoubted bacterial infection, the isolation of various bacteria of probable pathogenicity, favorable reports on the use of complete or partial vaccines, increased sedimentation rate, and the nature of the gross and microscopic pathology.

BACTERIOLOGY OF CHRONIC ULCERATIVE COLITIS

Against the supposition of a bacterial cause are to be considered the noncontagious endemiology, the lack of characteristic blood reactions, the great variety of bacteria suspected by different observers, the great differences in bacterial findings in different geographic areas, the frequent tendency to remission with and without treatment, the frequent ineffectiveness of vaccines, the common disagreement of careful bacteriologic findings in the same geographic area, and the postulation by proponents of any one bacterium that innumerable bacteriologic analyses are necessary to rule out the particular bacterium being considered. This last point deserves explanation. If twenty cultures are necessary before the discovery of the suspected organism, it does not at all follow that that particular organism has been present, undiscovered, throughout the series, nor does it follow necessarily, or even logically, that that organism has any etiologic relationship. It is equally, or even more reasonable to suppose that the suspected organism is temporarily in transit through the bowel, or is an inconsequential commensal or that, if the search is continued long enough, almost any organism may eventually be found, as in the case of B. dysenteriae in monkeys. The rich and highly variegated flora of the colon is constantly receiving additions by mouth and undergoing adaptations and transmutations in the constantly changing culture medium of the intestinal contents. Bacteria, whose origin lies in an extra-intestinal focus or portal of entry, as, for instance, the tonsils, sinuses, kidneys, and genital tract, are shed irregularly from the bowel. Analogy with the long search properly advised for protozoal parasites is completely illogical because of the sharp and extreme incommensurability of their respective biologic life cycles.

In spite of these contradictions and inconsistencies, a bacterial cause for chronic ulcerative colitis has been a proper field for investigation, and has attracted a rapidly increasing mass of study and number of workers. The chief bacterial theories can be summarized for our purposes here in brief terms. None has passed the stage of theory and some can only be regarded as hypotheses. An exhaustive listing is neither practical nor possible, nor is it possible to review the immense literature of the subject. Enough can be given briefly, however, to throw light on our own findings.

ETIOLOGIC THEORIES

I. *Chief Theory.*

The chief theory that has challenged attention and vigorous debate is the proposition that chronic ulcerative colitis is a continued infection with some type of dysentery bacilli, with a chronic course attended by exacerbations and often long remissions, inconstant appearance of bacilli in the stools, and either beginning as a bacillary dysentery of varying severity or resulting from an implantation of such bacilli on a different process, and a gradual localized build-up to the threshold of symptoms. It is impossible to consider all the literature on this thesis. Illustrative examples may be taken from papers by Hurst and others in England, Mackie, Felsen and others in New York, Zweig in Germany, and Throlakson in Canada, omitting numerous others.

A. F. Hurst[1] has discussed repeatedly the relation between bacillary dysentery and ulcerative colitis. He states that in 1921 he was so impressed by the similarity in appearance of the colonic lesions of bacillary dysentery and ulcerative colitis that he revived the suggestion of Saundby[2] made in 1906, and of Hawkins[3] made in 1909, to the effect that ulcerative colitis might be due to dysentery bacilli. In 1927, Hurst wrote that in no case had his colleagues been able to isolate B. dysenteriae in such cases from stools or with sigmoidoscope, and in no case had a positive agglutination reaction been obtained. He went on to state that he is doubtful if any other form of severe colitis exists except amebic, bacillary and chronic ulcerative.

In 1919, in the belief that ulcerative colitis was really an aberrant form of bacillary dysentery, Hurst administered polyvalent serum intravenously in large, repeated doses, with remarkable therapeutic results in the first case. Since that he has often used serum with excellent results, although occasionally with little or no effect. He notes the possibility of nonspecific protein reaction, and states that even severe reactions are never dangerous. In regard to the Bargen-Logan vaccine, in case the original infection is cured, Hurst asks what value results if there is left a residual secondary infection.

Thorlakson,[4] in Winnipeg, gives an interesting clinical experience which led him to the conclusion that ulcerative colitis is caused by dysentery bacilli. He secured his specimens for culture with the use of a small, sharp spoon-curet through the sigmoidoscope. He felt that the inclusion of some tissue from the ulcer bases by this method resulted in the easier finding of dysentery bacilli in culture.

Hern[5] discusses pathogenesis in a very complete fashion. He states: "As sole and primary cause, infection by intestinal flora is quite untenable. Ulcerative colitis bears no clinical or pathological resemblance to the few conditions in which the intestinal flora attack the large intestine—appendicitis and diverticulitis." He goes on to say that the relation of bacillary dysentery to ulcerative colitis is "altogether peculiar." "The two diseases are closely allied and may be one and the same. Even if not the same, the pathology of dysentery has a very direct bearing on the subject." He finds, however, that there is no substantial evidence in favor of the theory, and he finds it difficult to accept favorable serum therapy as confirmation.

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* From Division of Preventive Medicine, University of California Medical School.

Presented before San Francisco County Medical Society, December 6, 1938.

Mackie[6] has given an excellent review of the relationship of dysentery bacilli to chronic ulcerative colitis, and has reported one case of the latter with heavy infection of Flexner-Y bacilli which was completely cured by autogenous vaccine. In discussing this case, he notes that the Flexner-Y group of dysentery bacilli may cause mild clinical attacks which may not be epidemic. This is fully in accord with our own and other published experience. Mackie notes further that some such cases may become chronic, with lower bowel ulceration, even though the initial attack was very mild. He calls attention to the similarity or identity in kind of the lesions of chronic bacillary dysentery and many cases of chronic ulcerative colitis, and remarks on the intermittance of the shedding of bacilli as a characteristic of chronic Flexner-Y type infection.

In discussing the relationship of chronic ulcerative colitis to chronic bacillary dysentery, Mackie[7] notes frequent involvement of the small intestine, which then shows motor changes suggestive of acute exudative inflammation. In eighty-three cases, he recovered dysentery bacilli in 20.4 per cent, and obtained serologic evidence in an additional 21.6 per cent. In 102 controls, dysentery bacilli were recovered in two and positive agglutination was present in seven. He concludes that the evidence does not support the idea of a unitary cause of chronic ulcerative colitis, but he considers that a certain group of cases are due to chronic infection with dysentery bacilli.

Penner[8] believes that the available evidence indicates that about 10 to 15 per cent of cases clinically diagnosed as idiopathic ulcerative colitis, rightfully belong in the group of chronic bacillary dysentery, and the remainder are still of unknown etiology. He notes the preponderance of ulcerative colitis in the third and fourth decades, and its rarity in childhood, when bacillary dysentery is most common. Its occurrence, twice as often in women as in men, is against a bacillary cause, and also the relative infrequence of chronic ulcerative colitis among the males of central Europe, where bacillary dysentery was exceedingly prevalent during the Great War. He comments also on the noncontagiousness of chronic ulcerative colitis.

Felsen[9] attempts to relate nonspecific ulcerative colitis, acute bacillary dysentery, distal ileitis, ileitis and nonspecific granuloma, as various stages of one disease. He notes that cases of acute bacillary dysentery, lasting more than three weeks, seemed to persist due to nonspecific secondary infection. Much of his diagnosis, as in the case of many other writers, was based on blood agglutinations which are notoriously unreliable, if not useless. Felsen[10] admits that in nonspecific ulcerative colitis, the specific organism has usually died out and been replaced by secondary invaders, usually an enterococcus and B. coli.

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(To be continued)

WHAT CAN ONE EXPECT FROM RADIATION IN CARCINOMA OF THE RECTUM AND ANUS?*

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Discussion *by William H. Daniel, M. D., Los Angeles.*

I AM sure that every one of us has been confronted by patients who have had cancer of the terminal portion of the intestinal tract and who have asked, What may I expect from x-ray and radium therapy? Such a question is logical and one that should be answered with ease, especially since radiation has been a method of treatment in carcinoma for over thirty years. However, it is much more difficult than it first seems. In order to answer the question intelligently, it will be discussed in two parts—as it applies to carcinoma of the rectum, and to carcinoma of the anus. Though these forms of cancer are both found in the lower 15 centimeters of the large bowel, the problems involved are distinct as to anatomic relations and spread, and as to histologic structure.

COMMENTS ON THE LITERATURE

In reviewing the radiologic literature, one is struck by the absence of any appreciable mention of five-year cures. Sheddan, in reviewing the use of radium in rectal cancer, and presenting his results, has no five-year cures, but has two patients living at three and four years, respectively, with no evidence of disease. He mentions the various techniques used throughout the world, and he lists nine—evidence of the fact that no one of them is satisfactory. Bowing and Fricke report sixteen three-year cures and five five-year cures out of 286 cases. The workers in St. Mark's Hospital in London, namely, Lockhart-Mummery and Sir Charles Gordon Watson, used radium alone in a series of cases. Their results were very disappointing, since they had no five-year cures. However, the method of using radium was largely through the technique of Neumann and Coryn, in which the coccyx is removed and the bowel exposed so that platinum needles containing radium are implanted outside the rectum at the level of the tumor. Such a procedure is almost as formidable as the radical operation and has resulted in much postoperative shock, with death from the operation in some instances or a slow painful convalescence, usually complicated by prolonged infection, sloughing, and frequent recurrences. Mummery says that this procedure has been given up; and though he cites no five-year cures, he has had recoveries in early cases where he has used gold radon seeds intrarectally. Brinkley has also reported five-year recoveries following radon seeds and x-radiation at the Memorial Hospital.

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* Read before the Radiology Section of the California Medical Association at the sixty-seventh annual session, Pasadena, May 9-12, 1938.

AUTHOR'S OBSERVATIONS

In reviewing our experience during the past fifteen years, our results are similar to those obtained by other workers in this field. During that time we have treated 237 cases, which fell into the following groups:

(*a*) Inoperable: 167 cases, 40 of whom had colostomies.

(*b*) Recurrent: 32 cases, all of whom had had radical excision of the rectum.

(*c*) Operable: 38 cases, three of whom had colostomies.

In these patients no definite or set technique was followed. In the early cases many of them were inadequately treated, according to our present-day conception. We had no past experience to fall back upon, and the dosages used compared favorably with those employed in other parts of the body. Some were treated with low voltage x-ray, others with high voltage x-ray, while at present we are using supervoltage x-rays. Likewise, when surface applications of radium were used the radium was filtered through brass and rubber, while now it is filtered through gold and rubber. Some had interstitial radiation obtained from steel needles, but at present needles are used with .5 millimeter of platinum. Finally, some were treated with radon seeds made up with glass, but now these are of gold. We had no definite idea as to tumor dosage, since our conception of radiosensitivity was hazy. No accurate attempt was made to estimate the radiation absorption in the tumor obtained from either external or surface radiation. Even at that we did obtain some results that were encouraging.

INOPERABLE GROUP

In these patients one cannot hope for anything but palliation, as manifested by (*a*) diminution in size of the tumor; (*b*) relief from pain; and (*c*) cessation of bleeding, with resultant prolongation of life; for even in massive pelvic involvements the degree of benefit has at times been striking. The average length of life after the patient was first seen was one year, though many were followed for two and a half years and some for as long as four years before they succumbed to liver metastasis. Those patients who had colostomies did much better than the others, as radiation therapy could be carried out more effectively since infection was less and the bowel was at complete rest. In those individuals refusing colostomies, we resorted to electrocoagulation through the proctoscope. While the immediate results are good as far as the obstruction is concerned, fibrosis and contracture take place later which necessitates its repetition on one or more occasions. The occasional use of radiation preoperatively, especially radium, has resulted in transforming an inoperable case to an operable one. Bowing and Fricke speak of its use in this connection. Whether these patients exhibit a low rate of recurrence and a high rate of five-year curability is too early to state.

The histories of the following patients in this group are of interest.

REPORTS OF CASES

Case 1.—E. D. A. Seen in 1929. Sixty years of age. Complains of rectal bleeding and backache. Two months ago he had a colostomy elsewhere for obstruction and a carcinoma was found that had involved the posterior wall of the bladder, the prostate, and the sacrum. He was given three courses of high voltage x-ray therapy and two applications of radium in the rectum, filtered through brass and rubber. His bleeding and pain disappeared; he gained weight. He played golf every day, and was comfortable up to six months before he died—four and a half years after he was first seen.

* * *

Case 2.—J. F. D. First seen in 1932. Age, 51. He had had rectal bleeding for six months. Twelve days ago his physician had cauterized the growth and a colostomy was done. He was given supervoltage x-ray therapy and radium therapy in the form of radon seeds. He lived in comfort, carrying on his work as a pattern maker for three and a half years, when he died of liver metastasis.

* * *

Case 3.—H. G. First seen in 1933. Age, 55. He had rectal bleeding for four months. Two weeks earlier his surgeon had cauterized the growth, and a colostomy was done. Histologically, it was an adenocarcinoma, Grade IV. He was given two courses of supervoltage x-ray therapy, and radon seeds were plunged into the growth. He lived in comfort for two and a half years, when he suddenly died of brain metastasis. Autopsy revealed that the rectum was free from any evidence of carcinoma, grossly and microscopically.

* * *

Case 4.—B. D. First seen in 1936. Age, 50. Complained of intense backache and rectal bleeding of four months. Rectal examination showed a tumor mass partially obstructing the rectum, fixed to the anterior wall of the sacrum. Histologically, the tumor was an adenocarcinoma, Grade II. He was advised to have a colostomy, which he refused. He was given two courses of supervoltage x-ray. Radium platinum needles were plunged into the base of the tumor after the obstruction was relieved by electrocoagulation. Pain and bleeding ceased, and for two years he has been comfortable. He gradually developed an obstruction which necessitated a colostomy at the Veterans' Facility, where he died a week after the operation.

RECURRENT GROUP

In this group treatment was given to control growth and to relieve pain. All patients died within a two-year period, usually from infection in the operative field, though a few died from liver involvement.

OPERABLE GROUP

Here the problem is different. The lesion may be large or small and is not fixed. Our experiences in this group have been obtained by the use of radiation alone, or combined with electrocoagulation and colostomy. The following histories illustrate the point.

REPORTS OF CASES

Case 5.—Mrs. R. P. First seen in 1930. Age, 65. Three months ago she noticed rectal bleeding. There was a lesion two centimeters wide on the posterior wall of the rectum. Histologically, it was an adenocarcinoma, not graded. Radon seeds were implanted with disappearance of the tumor. She remained well until in February, 1938, when she died of liver metastasis. Locally, there was no evidence of tumor.

* * *

Case 6.—A. A. First seen in 1927. Age, 44. Complained of rectal bleeding of seven months' standing. Two weeks before, his physician had partly destroyed an adenocarcinoma with the cautery. Radium, filtered through brass and rubber, was placed on the base. A severe reaction took place, but the patient recovered and was living in 1938.

* * *

Case 7.—Mrs. P. D. First seen in 1935. Age, 45. For three years she had had rectal bleeding. A biopsy showed an adenocarcinoma. The surface of the tumor was cauterized, and radium, filtered through gold and rubber, in a surface application, was placed against it. At present she is well, two and a half years, with no evidence of tumor.

In this group we have also two individuals, both patients of Dr. E. C. Moore, on whom preliminary colostomies were done, after which radium was used.

Case 8.—Mrs. E. C. First seen in 1937. Age, 55. She had an adenocarcinoma 3 by 4 centimeters, 3 centimeters above the sphincter. Platinum needles, containing 2 milligrams each, were inserted beneath the tumor, with complete disappearance of the growth. This patient has been well one year and her colostomy has been closed.

* * *

Case 9.—W. L. First seen in 1937. Age, 63. He had a rectal tumor 2 centimeters in diameter, which was an adenocarcinoma. After colostomy, platinum needles, containing radium element, were inserted into the base of the tumor, and this was followed by its complete disappearance. His colostomy has been closed.

EPITHELIOMA OF THE ANUS

Carcinoma of the anus, which is really epithelioma of the anus, is discussed separately from the rectum, since the growth is of a different variety histologically, and because it metastasizes to the inguinal nodes, rather than to the lumbar nodes. It is accessible and, as such, may be removed by surgery or cautery with good results, but this usually results in destruction of the sphincter with its loss of control. Since epitheliomas on the skin, in the mouth, and on the cervix are successfully controlled by radiation, we feel that they can be treated just as successfully at the anal margin by the same method. Combined x-radiation with interstitial or surface radium in our hands have been very successful, as illustrated by the cases listed below. Even Mummery, who is an advocate of the radical operation for carcinoma of the rectum, says that epithelioma of the anal region is better treated by radium, and in such cases he always advises radium.

Our experience in this type of case is limited to twelve patients. Of these we have adequate records in nine. Two of the patients were advanced and died of metastasis after the primary lesion was controlled. The others all had complete disappearance of their tumors and have been followed from two to seven years. They are in good health and have complete control. The following histories are typical of this group.

REPORTS OF CASES

Case 10.—Mrs. F. L. First seen in 1932. Age, 65. Inside the anal margin is a nodular bleeding tumor 3 by 3 centimeters. Section shows it to be a squamous-cell epithelioma, Grade III. She was given a course of high voltage x-ray, and radium, filtered through gold, was applied to the base. Except for a stricture she has been well for six years.

* * *

Case 11.—E. W. R. First seen in 1934. Age, 68. For three years he has had a prolapse of the rectum. Recently an ulcer came on and biopsy showed that it was due to a squamous-cell epithelioma. Platinum needles were inserted around the anal margin. There was complete healing of the ulcer, with no anal disturbance. He is well now almost four years.

* * *

Case 12.—Mrs. F. K. First seen in 1936. Age, 52. Three months ago she began to have rectal bleeding and pain. On the anterior rectal wall, involving the sphincter, there was a bleeding tumor mass 4 centimeters in diameter. Section showed it to be a squamous-cell epithelioma, Grade III. She was given a course of supervoltage x-ray, and platinum needles, each containing 2 milligrams of radium, were inserted under the base. There was complete healing and for two years she has been well.

* * *

Case 13.—W. B. M. First seen in 1935. Age, 77. He has had fistulae and discharging sinuses around the anus for many years. He had a nodular infiltrating tumor completely surrounding the anus. It was 12 by 15 centimeters, and there were multiple fixed nodes in both groins. Histologically, it was squamous-cell epithelioma, Grade II. He was treated by supervoltage x-ray alone. The primary tumor disappeared, though the patient died six months later of general metastasis.

COMMENT

Despite the fact that rectal carcinoma carries an operability of only 50 per cent, and radical resection is followed by a mortality varying from 10 to 50 per cent—depending upon the type of operation—surgery offers the greatest hope of recovery. While many patients have recovered from radiation alone, they are the exceptional case and not the rule. However, up to the time that the radical operation was standardized, surgical end-results were extremely unsatisfactory, not only from the viewpoint of mortality but also from the standpoint of recurrence and five-year end-results. So, too, with radiation therapy: the technique has been in a flux, constantly changing, as our ideas of carrying out the procedure have changed. We now have improved equipment which will give greater depth doses from x-ray, while our knowledge of radiation effects and sensitivity have progressed greatly in the last decade. For these reasons one should expect better results in the future.

From a statistical viewpoint, the crux of the question is dependent on what the definition "oper-

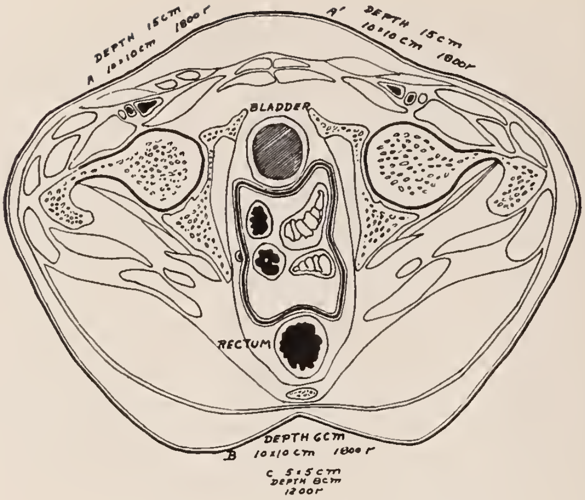

Fig. 1.—Section (male) above symphysis pubis.

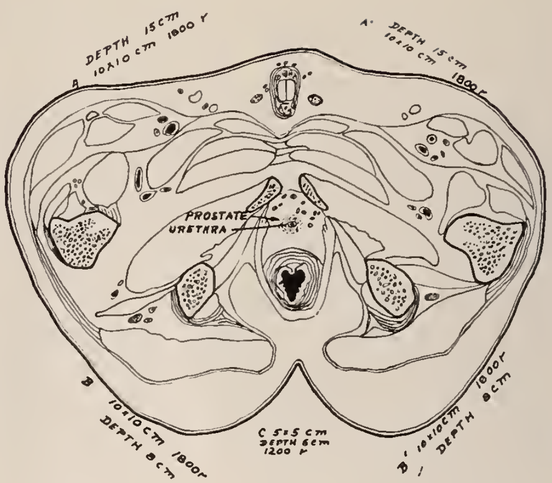
A DEPTH 15CM 10×10 CM 1800 r
A' DEPTH 15CM 10×10 CM 1800 r
PROSTATE
URETHRA
B 10×10CM DEPTH 8CM 1800 r
C 5×5CM DEPTH 6CM 1200 r
B' 10×10CM DEPTH 8CM 1800 r

Fig. 2.—Section (male) below symphysis pubis.

ability" means. This must be based on not only the extent and size of the lesion, but also the pathological grading of the tumor. Tumors graded III and IV are obviously more prone to recurrence than I and II when attacked surgically. As a matter of fact, a patient with a Grade IV tumor, no matter how early it is recognized, does not recover from a surgical attack, but the tumor will disappear after radiation. What constitutes "operable," then, is a matter of personal judgment. Obviously, patients who develop and die from recurrence locally were operable technically at the time of operation, but histologically not.

Curability.—Curability, as defined in the literature, is based on operability. All statistics are based on this factor—ignoring the vast host of patients who do not fall into this group. The patient who comes into your office, and who knows that he has cancer, is not interested in what artificial classification he falls into; he wants to know what can be done! (All statistics should be based on absolute figures.) Viewed in this manner, then, the quoted curability figures would be decreased by 50 per cent, and would only run from 10 to 15 per cent. While surgery does give us a better outlook in the strictly operable case, especially in Grades I and II tumors, it is time that both surgeon and radiotherapist should no longer be rivals but allies in this field. When Grades III and IV tumors are under investigation, the radiotherapist should be consulted before the operation regarding preoperative treatment in these groups; and, if possible, he should be an assistant so that he can be fully familiar with the existing conditions in the particular patient under consideration.

Adenocarcinomas in this region are deep-seated and are more or less inaccessible. While they have the reputation of being radio-resistant, I do not believe that cells of this type in this region differ greatly from those found in the breast or the uterus. Many will be found to be sensitive; the difficulty rests in getting enough radiation into the desired area. Knowing that squamous cell epitheliomas need about ten erythema doses to destroy them, it is reasonable to assume that adenocarcinomas will need this and more. Such dosage will naturally result in more or less fibrosis. Since the bowel wall is only 2 or 3 millimeters thick, and if the lesion is encircling and infiltrates the circular muscles, its disappearance will be followed by stricture formation and partial obstruction.

In order to attain a proper dosage, it is necessary to get the benefit of both x-ray and radium. This can be done by an estimation of the location of the tumor so as to be able to calculate the dosage from x-radiation. Referring to Figures 1 and 2, which represent tumors in two different locations in the rectum, we may see what must be expected. If four or five ports be used with 1800 r to each port, except the perineal, then a tumor dosage of three and a half erythema doses is obtainable in the average individual. If one desires, one may push the total dosage up to the skin-tolerance dose of 2400 or 3000 r over each port, with corresponding increase in tumor dose; but this may be followed by late undesirable sequelae in the skin and in the bladder. The difference between ten erythemas and three and a half or six and a half erythema doses must then be made up by the use of radium. Whether one should use radium as a surface application or interstitially, as radon or in platinum needles, will depend on the individual case; its dosage is easily calculated from the Quimby-Martin tables.

Colostomy.—While many patients may be successfully treated without a colostomy, the more one sees these individuals the more one feels that a preliminary colostomy should always be done with the understanding that if the treatment is successful and there is no fibrous stricture, the colostomy may be closed after a year. The colostomy puts the rectum at rest, the inflammation subsides, and the danger of infection and radiation necrosis is reduced to a minimum. Furthermore, since peristalsis and the presence of fecal matter is done away with, it is much easier to retain the radium in the desired location as long as it is needed.

With such improvements in technique, many operable cases of rectal cancer may be justifiably treated by radiation under the following conditions:

(*a*) Where the patient refuses operation.

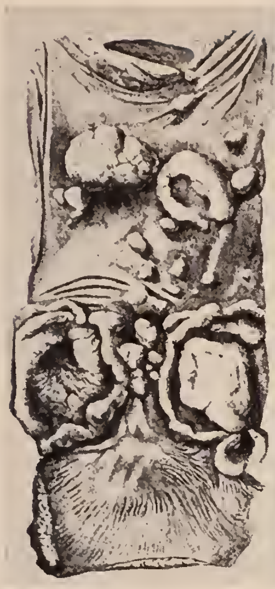

Fig. 3

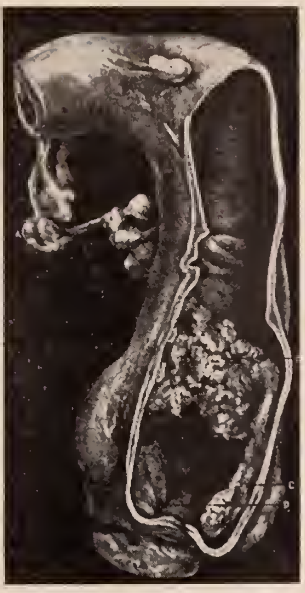

Fig. 4

(*b*) Where age and other complications preclude the radical operation.

(*c*) In the operable patient who has a small tumor of high-grade malignancy, which does not encircle the bowel and one in whom the proctoscope passes by readily. Here adequate dosage sufficient for complete destruction is obtainable by radon seeds or platinum needles. However, those operable cases that do not allow the passage of the proctoscope are not particularly suitable, since one cannot estimate the extent of the disease—as shown in Figures 3 and 4. In them it is impossible to use radon seeds with accuracy. Surface applications may be used, but the size of the area to be treated and the dosage must be a matter of conjecture. If radium is used in a contact applicator in order to get depth effect in a tumor from one-half to one centimeter thick, caustic effects are obtained on the surface, which add to the difficulties, as it results in necrosis, infection and rectal tenesmus. Since rectal cancers are slow-growing, and it has been estimated by various observers that a year elapses before the disease passes beyond the muscular coat, a trial of radiation, especially radium locally, will not jeopardize the patient's chances of recovery. If the radiation does not control the growth, the radical operation can still be carried out.

SUMMARY

In carcinoma of the rectum, radiation will stop bleeding and relieve pain in the majority of individuals. Occasionally, the inoperable case may become operable following its use. Though radiation therapy has been disappointing in the operable case when, computing five-year cures as compared with radical surgery, many patients are cured by its use; however, the percentage is not large. This may be improved by paying more attention to histologic structure of the tumor, by developing a better technique and by careful selection of suitable cases. Where treatment is contemplated, colostomy should be carried out, if possible, in operable as well as in inoperable cases.

In epithelioma of the anus, radiation stands on a par with surgery in end-results. While successful surgery invariably results in destruction of the sphincter, radiation is preferable, as the curability is high and sphincter control is retained. Therefore, radiation therapy should be the method of choice in this region.

1407 South Hope Street.

DISCUSSION

William H. Daniel, M. D. (1930 Wilshire Boulevard, Los Angeles).—We all regret that radiation has not given us the results in carcinoma of the rectum that we had hoped for. Very thorough and detailed treatment has been carried out by many workers in different parts of the world. The results reported correspond very closely to those Doctor Meland has recounted here. I have seen several patients who have been treated with deep therapy and who remained fairly comfortable for several months or longer. There is still some variance of opinion whether radiation will affect the metastases at some distance from the tumor. There is also dispute as to the value of preoperative and postoperative treatment.

My personal experience with radiation treatment has been limited. I have had the opportunity to follow some cases treated by this means, and some cases which had had only preoperative radiation and some postoperative radiation. Several years ago, when the high voltage was first used, I was not impressed with the results. With the newer methods of treatment, I am convinced that there is value in selected cases, and I am positive there is a field for this procedure in the poor risk, or inoperable case. In cases that are distinctly operable, or borderline, I still feel that surgery alone is the best procedure.

In epithelioma of the anus, which constitutes less than 5 per cent of the total, I have been convinced that radiation by radium and x-ray is to be considered as efficacious as surgery alone. My results with surgical treatment, even with radical procedures, have been disappointing due to recurrence or early metastases. These cases are apparently more malignant than the adenocarcinoma. A combination of radiation and surgery might, in these cases, answer the problem.

SULFANILAMIDE: SOME IMMUNOLOGICAL STUDIES*

By Paul Michael, M.D.
Oakland

Discussion *by John Dougherty, M. D., Oakland; Albert M. Meads, M. D., Oakland; Angus Wright, M. D., Los Angeles.*

The history of sulfanilamid dates back to 1908 when Gelmo,[1] a German dye chemist, synthesized the compound for that industry. In 1909, Hoerlein, Dressel, and Kothe[2] prepared the first azo dye stuffs with sulfanilamid radicles, but no pharmacological investigations were conducted. In 1917, Jacobs and Heidelberger,[3] of this country, synthesized meta-amino-benzene-sulfonamid and para-chlor-acetyl-amino-benzene-sulfonamid, and combined it with hydrocuprein through the azo linkage.[4] They stated that their colleague, Dr. Martha Wollstein, would discuss the bactericidal properties of these drugs in a subsequent paper. This, unfortunately, was never published. In 1932, Mietzsch and Klarer[5] patented a new dye now known as prontosil. Domagk,[6] working in conjunction with these dye chemists, demonstrated the therapeutic value of prontosil rubrum in mice streptococcal infections. These same chemists later were successful in the synthesis of the more soluble compound, which is the prontosil solution now in common use. That these dyes were broken down in the tissues to para-amino-benzene-sulfonamid, now known as sulfanilamid or prontylin, was postulated by Tréfouel and coworkers.[7] This was substantiated by Fuller,[8] Marshall, Emmerson and Cutting,[9] who found sulfanilamid in urine of patients after having received an intravenous injection of prontosil. The efficacy of these drugs in certain infections is widely accepted even though the mode of action has never been solved. Marshall, Emmerson and Cutting[9] have shown that the optimum concentration for the action of this drug on organisms *in vitro* is 10 milligram per cent. They have also demonstrated that only by a prolonged dosage of 80 grains a day can this accepted blood level of 10 milligram per cent be maintained in human beings. Osgood,[10] on the other hand, has shown that the concentration of one milligram per cent of sulfanilamid is effective against Beta hemolytic streptococci in human bone-marrow culture. Fuller[8] believes that effective therapeutic results *in vivo* have been obtained with only a concentration of one milligram per cent in the blood.

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* Read before the Pathology and Bacteriology Section of the California Medical Association at the sixty-seventh annual session, Pasadena, May 9-12, 1938.

Attempts to correlate *in vitro* experiments with *in vivo* therapeutics, in order to achieve a clear conception of the mode of action of the drug, leads to innumerable pitfalls. For instance, it has been shown that sulfanilamid has no effect *in vitro* against B. aertryke, B. typhosus, B. paratyphosus B., and pneumococcus, whereas the drug protects mice against these infections. Furthermore, Long and Bliss[11] have demonstrated bacteriostatic effects *in vitro* for alpha and gamma streptococci, and yet treatment of these clinically has given very discouraging results. Kenny, Johnston and Von Hoebler[12] found that urines containing para-amino-benzene-sulfonamid were bacteriostatic to some strains of B. coli, but other strains were unaffected *in vitro,* yet were successfully controlled in human infections. In the hope of a possible contribution along these lines, numerous experiments were conducted in the Peralta Hospital laboratory during the past year in an attempt to evaluate the importance of phagocytosis and bacteriostasis of para-amino-benzene-sulfonamid or sulfanilamid.

PHAGOCYTOSIS EXPERIMENTS

The organism used was a fast-growing strain of gonococcus. It was grown in hormone broth containing 0.5 per cent glucose and 25 per cent ascitic fluid, and also on blood-agar slants. In the former case the organisms were separated by centrifugalization and resuspended in physiological saline. In the latter case the organisms were harvested from a thirty-six-hour slant with physiological saline. In both instances the heavier aggregates of organisms were removed by the centrifuge at low speed. The supernatant suspension was diluted to contain one-half billion organisms per cubic centimeter.

Five cubic centimeters of human blood were collected with a drop of 20 per cent potassium oxalate, to prevent clotting. Heparin 1-2,000 and 0.4 per cent sodium citrate were used also in a few instances without appreciable differences. To 2 cubic centimeters of blood in a test tube was added 0.1 cubic centimeter of 0.4 per cent para-amino-benzene-sulfonamid (Eastman) in physiological saline. To a control tube containing 2.0 cubic centimeters of blood was added 0.1 cubic centimeter of saline, and to both these tubes 2.0 cubic centimeters of bacterial suspension were added. The experimental tube now contained 10.0 milligram per cent of the drug. The two tubes were placed in a water bath at 37 degrees, attached to and mechanically shaken by an electric shaking device to maintain constant motion. Every three minutes capillary pipettes were inserted in the tubes and blood smears made from both. The smears were stained by Wright's stain, and the number of organisms phagocytized by 50 polymorphonuclear leukocyte neutrophils were counted.

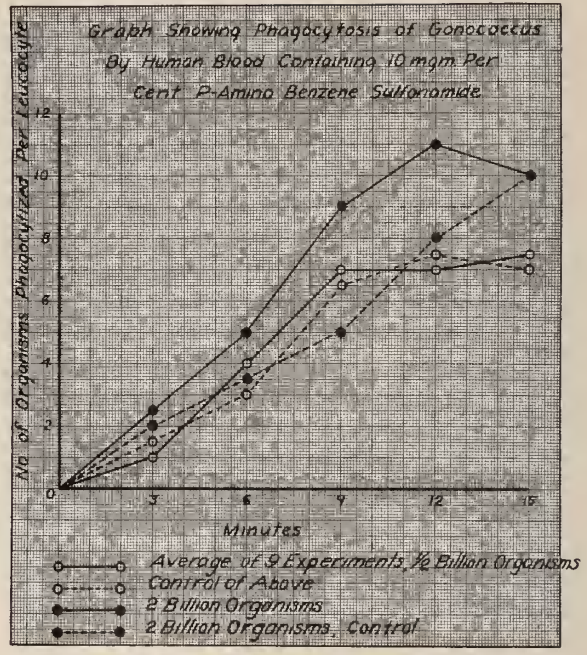

Chart 1

There was no appreciable difference seen between the control and experimental tubes in any of the experiments. In the experiments in which two billion organisms per cubic centimeters were used, there was some increase in phagocytosis over the control. The obvious probable error in manipulative technique with such a large inoculum minimizes the significance of the apparent slight increase in phagocytosis. The results of the above experiment are recorded in Chart 1, showing a composite of the many experiments. Smears made at one-hour and two-hour intervals (not shown in the graph) showed the same proportions between experimental and control tubes, although a larger number of organisms had become phagocytized.

BACTERIOSTASIS EXPERIMENTS

Strains of alpha, beta, and gamma streptococci, B. coli, Staphylococcus aureus and gonococcus were next investigated in the presence of sulfanilamid. One-tenth of a cubic centimeter quantity of twenty-four-hour cultures was inoculated into flasks holding 20 cubic centimeters of glucose-hormone broth containing 1.0, 10.0, and 100.0 milligram per cent para-amino-benzene-sulfonamid. The culture media for gonococcus included also 25 per cent ascitic fluid. Control tubes contained the same inoculum of organisms, but no drug. In order to determine the effect of acidity or alkalinity, these experiments were conducted at a PH of 5.3, 6.0, 7.4, and 8.2. The results of these experiments were tabulated in Table 1. In only one instance was there any bacteriostatic effect noted. Gonococcus was partially inhibited by one milligram per cent of the drug and completely inhibited by 10 and 100 milligram per cent. In none of the other experiments was the drug effective in causing inhibition of growth. This result naturally raises the question of selective and specific action of sulfanilamid on the gonococcus. This would assume, then, that the drug acts on some organisms in one manner, and on other organisms in another manner. Such a concept does not conform to the accepted ideas of immunity or therapeutics, for its mode of action should be consistent against all organisms.

In one set of experiments, rabbits varying between 1 and 4 kilograms in weight were injected over a period

TABLE 1.—*Bacteriostatic Effect of Prontylin at Several Hydrogen Ion Concentrations*

Organism	pH	Prontylin 1 Mg. Per Cent	Prontylin 10 Mg. Per Cent	Prontylin 100 Mg. Per Cent	Control
Gonococcus	7.4	2+	Negative	Negative	4+
Beta hemolytic streptococcus	5.3	4+	4+	4+	4+
	6.0	4+	4+	4+	4+
	7.4	4+	4+	4+	4+
	8.2	4+	4+	4+	4+
Staphylococcus aureus	7.4	4+	4+	4+	4+
	5.3	4+	4+	4+	4+
	6.0	4+	4+	4+	4+
	8.2	4+	4+	4+	4+
B. coli	5.3	4+	4+	4+	4+
	7.4	4+	4+	4+	4+
	8.2	4+	4+	4+	4+
Alpha streptococcus	6.0	4+	4+	4+	4+
	7.4	4+	4+	4+	4+
Gamma streptococcus	7.4	4+	4+	4+	4+

of three days with a total of 4 grams of the drug in physiological saline. Three and one-half cubic centimeters of blood were collected from the heart and defibrinated. The concentration of the drug, as determined by the method of Marshall, Emmerson and Cutting,[9] was found to be 2 milligram per cent. The blood was next added to an equal value of hormone broth containing alpha, beta streptococci and Staphylococcus aureus. There was no inhibition noted in the growth of any of these organisms. As this is the blood level achieved in most clinical studies wherein satisfactory therapeutic results have been reported, it is probable that the beneficial effects obtained are not due to a direct bacteriostatic action.

COMMENT

Many paradoxical experimental results are cited in the literature of the variability of para-amino-benzene-sulfonamid on different strains of organisms. On the other hand, many explanations have been offered for the mode of action of the drug. To date, they include:

1. Germicidal action.
2. Specific action on the carbohydrate capsules of organisms.[13]
3. Increased phagocytosis.[11]
4. Bacteriostasis.[11]
5. Combination of bacteriostasis and phagocytosis.
6. Antitoxic effects.[10]

Most workers are convinced that para-amino-benzene-sulfonamid in safe therapeutic concentrations is not bactericidal, and that it is more effective on the noncapsulated organisms than on those with capsules. We are left, therefore, with the other theories which, at the present time, seem to be the most logical and plausible, either in part or in combination. The results of the experiments herein cited in this paper do not bear out the claims cited by Long and Bliss[11] on the phenomenon of phagocytosis. On the other hand, these same authors claim that sulfanilamid has bacteriostatic action on Clostridium welchii, both *in vivo* and *in vitro*. In other words, according to them sulfanilamid, by its bacteriostatic action, slows down the multiplication of organisms, allowing more thorough and effective phagocytosis. With the exception of a definite inhibition of growth of gonococcus in the presence of the drug, we were unable to show any bacteriostatic effects on several organisms.

Osgood,[10] working on human bone-marrow cultures, concluded that sulfanilamid is effective on the beta hemolytic streptococcus by virtue of its antitoxic properties. According to this theory, however, sulfanilamid is dependent upon the production of an exotoxin by the organism in question. This method of Osgood opens up a very interesting avenue of research on the problem, but leaves many questions unanswered.

It is our feeling that this problem, as it exists at the present time, is far from solved. There is too large a gap between the experimental data and the analogies and theories of explanation. It is our thesis that the experimental data accumulated so far end with an unsatisfactory explanation. Our experimental work to date leads us to believe that the action of sulfanilamid is not explained on the basis of its bactericidal, bacteriostatic, or phagocytic action *per se*, but probably from some chemical or immunological reaction yet to be determined.

IN CONCLUSION

1. Pertinent literature on para-amino-benzene-sulfonamid (sulfanilamid) is reviewed.

2. No stimulation of phagocytosis of human neutrophils for gonococci by para-amino-benzene-sulfonamid could be demonstrated *in vitro*.

3. Concentrations of 10 milligram per cent and 100 milligram per cent of para-amino-benzene-sulfonamid inhibited growth of gonococcus in culture.

4. One hundred milligram per cent of the drug did not inhibit the growth of alpha, beta, or gamma streptococci, Staphylococcus aureus, or B. coli *in vitro*.

5. Rabbits' blood, containing 2 milligram per cent of para-amino-benzene-sulfonamid by intravenous injection, did not become bacteriostatic to alpha, beta, and gamma streptococci.

6. No theories are put forth as to the probable action of sulfanilamid, and the question is raised as to our present concept.

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DISCUSSION

John Dougherty, M. D. (3115 Webster Street, Oakland).—Since the use of sulfanilamid has become routine in the treatment of gonorrhea it has been apparent that there was a wide variation in the clinical response of the gonococci to this drug. With a view of estimating the frequency of the difference in its behavior, a study was made of seventy-five cases of acute gonorrhea. Inasmuch as in certain complications of gonorrhea (peri-urethral abscess, prostatic abscess, etc.), sulfanilamid seems to be ineffectual, we were careful to select only those cases which were free from complications. These seventy-five men were then given sulfanilamid, orally, in the dosage of grains thirty in twenty-four hours. No other treatment was administered, except a twice-weekly irrigation with potassium permanganate. The patients, all of the clinic variety, were seen at the Oakland Health Center, and the conclusions here drawn are subject to the usual objections due to the type of coöperation one encounters in such material.

With this condition in mind, the following observations were noted: Number of cases, 75. Discharge ceased in three to seven days, 12; in seven to ten days, 7; in ten to fifteen days, 23. No change, 25. Reaction, 8. Treatment changed.

Of the twenty-five cases which showed no response, thirteen were thought to be getting worse and were put upon other treatment. The remaining twelve, who were unimproved, were put upon 50 grains daily in divided doses. Of these only one showed any improvement. All the patients who tolerated the drug in small doses were able to tolerate the increased amount. In this study the therapeutic efficiency of sulfanilamid seemed to be as great in the small as in the larger doses. It is further to be noted that the resistance strains of gonococci were not affected by the change in amounts administered. If this be true it is suggested that, until the pharmacology of sulfanilamid be understood, the interests of conservatism might best be expressed in the smaller doses.

Albert M. Meads, M. D. (251 Moss Avenue, Oakland). The remarkable response of certain infections to sulfanilamid therapy has made its acceptance by the medical profession as spectacular as that of salvarsan or insulin. The treatment of acute infections of the urinary tract, particularly, has been so improved under the use of this new drug that the time of treatment has been greatly reduced and instrumentation almost eliminated, except for diagnostic purposes. Many chronic infections, where no foreign body or anatomical distortion exists, clear up almost over night, after baffling the physician for months under the older methods of attack. So remarkable have been the results following sulfanilamid therapy that the profession at large has accepted the new drug for its face value, leaving to the laboratory to thresh out the why of its action in the body. The fact that it works is ample cause for its use in the clinical mind.

However, most of us welcome an explanation of the action of any drug in producing its therapeutic effect. So in the case of sulfanilamid we have accepted the statement that the "bactericidal properties are greatly in excess of anything encountered in normal blood and serum" when sulfanilamid therapy has been employed. Also, we have considered that the "infecting organisms are rendered more susceptible to phagocytosis." Both of these statements were questioned by Doctor Michael and have been disproved, apparently, as far as his experiments are concerned.

That a certain high concentration (10 milligrams per cent) level is necessary for clinical results has been emphasized. Clinical experience, however, in urologic infections has definitely proved that smaller doses than were originally advised will bring about the desired result with less chance of toxic complications. Excepting gonococcal infections, five grains, four times a day, is the average dosage used by us, and the results have been most satisfactory. One remarkable case of proteus infection, treated at intervals for three years under the older methods without any appreciable change, absolutely cleared up in three days under the above dosage, and, believe it or not, has remained pus-free and bacteria-free ever since.

In spite of the fact that the mode of action of sulfanilamid in the body is still a debatable question, and that the work of Doctor Michael has changed one's view as to the accepted theory of its bactericidal properties, the clinical results are so positive that we shall continue to use it while awaiting the solution of this problem.

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Angus Wright, M.D. (657 South Westlake, Los Angeles).—It is heartening, in face of the widespread and all too frequently indiscriminate use of sulfanilamid, to see efforts directed toward determination of the mode of action of the drug.

As Doctor Michael has indicated, there are discrepancies between the *in vivo* and *in vitro* action of the drug on certain organisms. Explanation of the cause for this difference in action in the test tube and in tissue—if it is an actual one—offers an intriguing problem and one which, if solved, might open an entirely new field in chemotherapy.

On the basis of the phagocytosis experiments it is evident that there is nothing in sulfanilamid which enhances phagocytosis, either *per se* or through augmentation of opsonins. It would certainly be out of line with established observations in immunology if a chemical added either *in vitro* or *in vivo* could increase either one of these fundamental defensive mechanisms.

As a discussant, it is easy to apply interpretations which the essayist might well be more chary of. I feel, however, that Doctor Michael's results on bacteriostasis, as well as other published work and clinical observation, indicate that the primary and probably the only action of sulfanilamid is purely on the basis of its chemotherapeutic action. I think it likely that the apparent paradoxes in behavior will be explained on the basis of differences in experimental method rather than in action of the drug. The fact that in clinical pathology we see most effective results with sulfanilamid in cases where the blood level of the drug is high would seem to favor the opinion that efficacy of the drug is due to its direct chemical action.

FOREIGN BODY IN THE IMMATURE VAGINA

By Goodrich C. Schauffler, M.D.
Portland, Oregon

Discussion *by Alice F. Maxwell, M. D., San Francisco; Roy Fallas, M. D., Los Angeles.*

In spite of the rarity of this condition as a clinical entity, its discussion is deemed important for two reasons: First, because its occurrence masquerades as vaginitis or vulvovaginitis and is mistaken for this condition, when the patient is needlessly and harmfully treated as a victim of gonorrhea; and, second, because in each of four instances there has been noted a bloody component to the vaginal discharge, which, if not pathognomonic, is highly suggestive. Its occurrence is here signalized as of notable importance in differential diagnosis.

CLINICAL MATERIAL

Out of a series of 319 immature females treated for vulvar and vaginal disorders, 266 presented vaginal discharges requiring complete investigation. Out of this group, four, or .015 per cent, were proved to have a retained foreign body in the vagina (Fig. 1). Although three of the patients had formerly been seen by physicians (one patient by two doctors), the correct diagnosis had in no case been suggested prior to our investigation. Two of these children had had active treatment in the form of vaginal instillations and irrigations over a period of weeks to months. In one case a supposedly definite diagnosis of gonorrhea had been made, with the psychic trauma to child and family which inevitably follows. In three of these individuals, smears had been taken repeatedly—this procedure apparently not in any case indicating the proper diagnosis. It is hardly necessary to signalize the harm and injustice which may occur as a result of such faulty diagnosis in this connection.

These children ranged in age from three to twelve years. Two were definitely from the underprivileged group, one in the high middle class, another from a family of some social standing. It is of interest that, whereas a reasonably careful psychological study was made in each instance, and in three instances a fairly complete past history, including environmental factors and excellent follow-up was available, only one of the three appeared to be the "naughty little girl" type. The other two were, so far as we could determine, ingenuous, well behaved, and entirely above suspicion of conscious wrongdoing. These children—and, incidentally, a number of others whom we have seen in the course of other conditions involving the genitalia—were in all respects normal, apparently in this instance motivated by curiosity or an exploratory bent, such as dictates the insertion of foreign bodies into the nose or the ear. In no instance had the child announced the possibility to its parents. From two of the children, when the matter was brought to their attention, an apparently frank admission was obtained. A third child had been a problem child to its parents for something over a year. She was a confirmed masturbator, had been frequently involved with little boys in the neighborhood, and apparently had a definite fixation in relation to her genitalia. Interestingly enough, this child consistently denied that a safety pin could have been inserted into her vagina even when the object was produced. This was an older child, seen five years ago, at the age of twelve, and has since acquired gonorrhea, had an illegitimate pregnancy, and undergone a severe postabortal infection. The fourth patient was seen so briefly—merely for the removal of the foreign body—that the psychologic background could not be investigated.

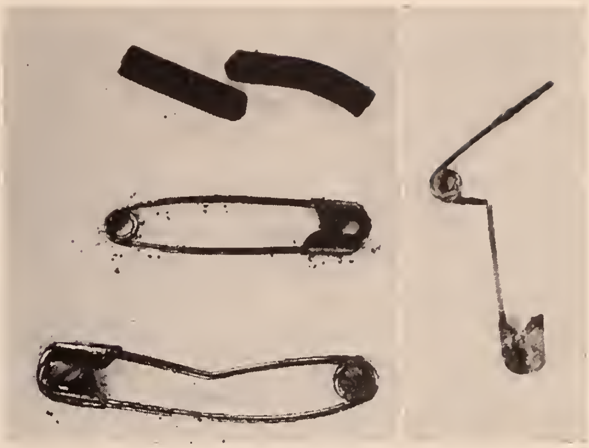

Fig. 1.—Foreign bodies removed: (a, upper left) a red crayon from a child aged five—duration a few weeks; (b, middle left) a safety pin from a child aged twelve—duration unknown; (c, lower left) a safety pin from a child three years of age—duration at least three months; (d, right) a safety pin removed from the vagina of a child aged seven. Note erosion, loss of tip. Safety pin had to be bent and removed open. There was definite embedding, with areas of vegetation. Duration at least eight months, possibly two years. Recovery immediate and complete.

DIAGNOSIS

A single observation, consistent in each of these four instances, by itself justifies the publication of this report. In each case there was a definite bloody component to the vaginal discharge noticed almost from the beginning of the complaint. In other respects the clinical picture differed so little as to be routinely mistaken for typical so-called vulvovaginitis. That the admixture of blood in the vaginal discharge is not common to infections of the immature vagina—even in virulent acute gonorrheal infections—is attested by our observations in 266 instances. Rarely (in only three instances) did we note slight transient bleeding due to demonstrable vulvar erosion or cracking. This condition was not persistent and so was quickly amenable to local treatment. The only other instance of persistent serosanguinous vaginal discharge occurred in a child, age 13, who had a virulent trichomonas vaginitis. Occasional instances of transient cervical oozing due to instrumentation have been noted. Otherwise, persistent serosanguinous vaginal discharge has been restricted exclusively to the cases of foreign body. We believe that the observation is one of considerable importance in this connection, especially since the diagnosis seems to be so easily overlooked on the basis of commonly recognized symptoms.

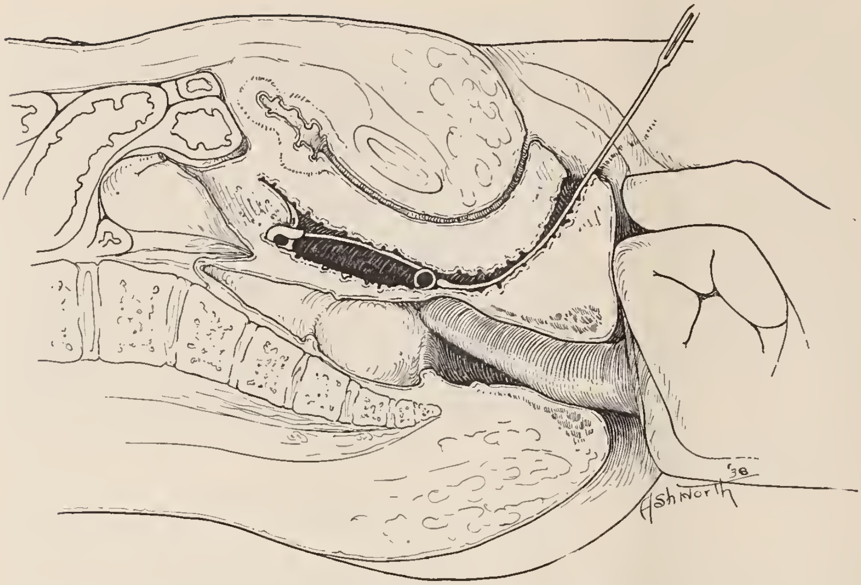

Fig. 2.—Schematic drawing illustrating diagnostic method and methods of removal, with little finger of left hand in the rectum. The rectal finger greatly facilitates location of the foreign body and appears definitely to distract the child's attention from the vaginal manipulation. Small forceps may be used for extraction in the same way.

In our entire experience we have never obtained an admitted or suspected history of foreign body prior to its diagnosis. The history, therefore, except in so far as masturbation or vaginal manipulation may indicate the type of child, is seldom helpful. The presence of a profuse, irritating, non-specific vaginal discharge, not affected by the usual type of treatment, should cause immediate suspicion. If beyond this there is a persistent bloody component to the discharge, foreign body should be suspected. It is our practice to investigate the vagina under direct vision through a small urethroscope in every instance where routine treatment is not reasonably effective. Should such an instrument not be available, or the patient's reactions unfavorable, the following method will be of assistance: A small caliber, dull-nosed metal probe may be introduced into the vagina without notable disturbance. Should there be a metal foreign body, the probe will be fairly felt to click against the metal. This sensation is almost unmistakable, but may occasionally be similated by the catching of the probe in the vaginal crypt with its sudden escape. If the foreign body is not metallic, the method is not helpful, although in one case (where a red crayon had been inserted) a small particle of the colored material was brought away on the end of the probe. A more effective method which we have devised is as follows (Fig. 2): The little finger of the left hand, well lubricated, is inserted into the rectum. The metal probe is then carefully carried up the vaginal wall, its course being followed by the finger in the rectum. Irregularities and impediments to the passage of the probe may then be investigated. In two instances, foreign bodies have been clearly outlined between the probe and the rectal finger—once after the passage of the probe alone had not revealed the object. Diagnosis is thus made easily and relatively painless. It should be pointed out that this procedure seldom alarms or distresses the patient, the probe being passed more easily with the rectal finger in place; whereas the urethroscope is occasionally difficult to use without heavy restraints or anesthesia. This method is particularly valuable in smaller children.

TREATMENT

In older children (say five years or over), who are reasonably coöperative, the removal of a foreign body may be undertaken without anesthesia. In our patient, age three, a large encrusted safety pin was removed without complaint. A special grasping instrument, such as is used in the bladder or the kidney pelvis, may be used through the vaginoscope. In general, however, a rectal finger will guide a small hemostat successfully to the object, which may be grasped and removed with care. Should the patient be uncoöperative, it is, of course, highly desirable to induce anesthesia with nitrous oxid or ethylene. In the case of metal objects, particularly safety pins (which seem popular), care must be exercised in relation to whether or not the pin is open. This should be suspected, particularly if the history is of long duration. In a recent instance, for example, the protected end of the pin had eroded away completely, so that the pin had sprung and presented itself with the open end downward. It could only be removed by bending, and with some injury to the soft tissues (Fig. 1). In two instances where we found metallic parts of the safety pin partially embedded in the vaginal wall, their removal entailed considerable bleeding. The vegetations in the areas involved, however, have almost immediately absorbed without further complication.

Intravaginal instillations or douches have not been used in our four patients following the removal of the foreign body. The vagina was distended with bland antiseptic ointment in two of the children. In all instances, within two or three days, the vaginal discharge has decreased. Within a week, except in one instance, it has disappeared; the external irritation has also disappeared, and the condition has returned to normal within two weeks. Visual examination has shown complete restoration of the vaginal walls, and a normal vaginal reaction, together with normal flora, has returned.

It should be pointed out that the psychic composure of the patient appears to be little upset except by her reaction to alarm or deep concern on the part of the parents or physician. It is our impression that the management of this condition should be surrounded by an air of nonchalance, such as accompanies any other painful and unpleasant medical procedure. The morbid aura which is so often allowed to invest an episode of this sort is particularly harmful in childhood. Since the child's attention is already no doubt somewhat centered upon its genital apparatus, it is my belief that the lightest possible psychic touch is required. As we have stated before in relation to vaginitis, any sort of complicated psychotherapy seems more indicated for the parents than for the affected child.

IN CONCLUSION

1. Because out of four cases of foreign body in the vagina of female children (0.015 per cent of 319 patients examined for vaginal and vulvar complaints), three were previously unrecognized by physicians, two of the patients being strenuously treated for vaginal infections, one stigmatized with an incorrect diagnosis of gonorrhea, this clinical note is deemed justified.
2. The constant presence of a persistent bloody component to the vaginal discharge—rarely noted in other conditions—is established as an important contribution to early diagnosis.
3. A discussion of diagnosis and treatment is given in sufficient detail to be helpful.
4. Psychological factors are briefly considered.

548 Medical Arts Building.

DISCUSSION

Alice F. Maxwell, M. D. (University of California Hospital, San Francisco).—This is a report of particular interest since it emphasizes two important points, namely, the relative infrequency with which foreign bodies are found in the vagina of children, and secondly, the necessity of an accurate diagnosis of a purulent bloody vaginal discharge in individuals of any age.

The presence of foreign bodies (peas, beans, buttons, etc.) in the aural and nasal passages of children is so common as to excite little comment. The assortment of objects which have been removed from the bladder of individuals, usually adult, arouses speculation as to the ingenuity and disregard of pain which permitted the introduction of safety pins, crochet hooks, gauze, rocks, etc. The rectum has, likewise, served as a receptacle for foreign bodies. The relative ease of accessibility of the vagina, and the fact that even in children the structures in its neighborhood are associated with sensations of sexual stimulation (judged by the frequency of masturbation), would justify the assumption that self-exploratory investigation of children should lead to the discovery of the vaginal canal frequently. The reports in the literature of such occurrences are rare, yet the careful observations of the author disclosed this situation in four of 319 children whom he had under observation for vaginitis.

It is difficult to explain a physician's negligence in establishing a diagnosis and casual attitude in treating a child with a bloody vaginal discharge, since it has long been recognized that this sign usually indicates a malignant lesion in the pelvic organs. With this possibility in mind, a most thorough investigation of the pelvic organs is imperative: had a careful examination been made in three children, the diagnosis would have been obvious. It is not unreasonable to expect that the medical attendant would have an investigative urge at least comparable to that of his young patients.

The author is to be congratulated for directing our attention to an interesting problem and for emphasizing the necessity of establishing an accurate diagnosis.

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Roy Fallas, M. D. (1930 Wilshire Boulevard, Los Angeles).—Although, as stated by the author, a foreign body in the immature vagina is very uncommon, all gynecologists should be properly equipped for making a careful visual examination as painlessly as possible, in all cases of persistent vaginal discharge.

It has been my practice to use a small Kelly endoscope, through which topical applications can be made, as well as foreign bodies appropriately dealt with.

The wonder is that foreign bodies are not more frequently found, particularly when it is realized that negro children, at least in certain parts of this country, are taught by their mothers the art of masturbation for the purpose of keeping them from crying and being a nuisance to their parents.

Doctor Schauffler has, I believe, offered an ingenious method of investigation by probing the vagina over a finger in the rectum. However, in the case of a metallic foreign body, its presence or absence can be readily and painlessly established by an x-ray picture.

I believe that in all cases of persistent, chronic, vaginal discharge, the possibility of a foreign body should be ruled out.

DIPHTHERIA*

A STATISTICAL REPORT OF 3,344 CASES

By J. C. Geiger, M.D.
R. W. Burlingame, M.D.
and
Hilda F. Welke, A.B.
San Francisco

In consonance with other cities in these United States, the morbidity and mortality of diphtheria in San Francisco have undergone considerable fluctuations over the period 1917–1937, inclusive.

SAN FRANCISCO DIPHTHERIA MORBIDITY RATES IN DIFFERENT YEARS

The morbidity in 1917 showed a case rate of 172.0 per 100,000. The rate, however, rose to 309.84 in 1923, the highest ever recorded, and the periods 1921–1924, inclusive, could be considered epidemic years for diphtheria, or, at least, those in which the disease offered the most difficulties for the establishment of control measures. In 1925, a decided downward trend prevailed, and the decline in rate per 100,000, from 108.02 in 1925 to 7.65 in 1937, is more than gratifying to health officials. The mortality rate per 100,000 in 1917 was 13.60, and reached its highest in 1923—26.84. The decline in mortality rate noted in 1925 to 6.41 has been steadily maintained until in 1934 the all-time low of 0.15 was reached; and in 1935 and 1936 the rate was 0.58. In 1937, however, due to a sharp outbreak of the disease in adults in several subnormal and crowded lodging houses, and delay in reporting and hospitalization, the rate rose to 1.15. The number of cases reported for 1937 was fifty-three, and if the measures for control now in use are maintained, this disease as a clinical entity will probably disappear in San Francisco, or will have reached the terminology of the irreducible minimum. The importance of immunization with toxin-antitoxin or toxoid has been stressed in such recorded reduction of morbidity. Immunization was started in San Francisco about 1920. It was only routinely adopted, however, by the then San Francisco Board of Health for the children in the Well-Baby Centers and in the schools in May, 1924. The number of school and preschool children immunized has increased each year since 1924, when the number recorded was 1,605. In 1937, the immunized group was 4,701. This figure does not, however, present a fair picture of immunization.

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* From the Isolation Division, San Francisco Hospital.

In the report of the committee of the San Francisco County Medical Society, which constituted a complete survey of hospitals, clinics, and records of private psysicians, the conclusion was reached that 80 per cent of preschool, and 60 per cent of children in elementary schools are immunized. Moreover, this committee pointed out that, though mass immunization of such groups is desirable, the responsibility of early immunization was placed on the practicing physician. In investigation of the students of medical and dental schools of San Francisco, it was shown that 65 per cent of these groups had positive reactions with the Schick tests, and comparatively few gave histories of immunization.

ANALYSIS OF CASE RECORDS: PERIOD OF TWENTY-ONE YEARS

The Department of Public Health has maintained an Isolation Division in the present San Francisco Hospital for nineteen years. It was considered important to analyze statistically such cases treated in this institution for the period of 1917 through 1937. In all, the records of 3,344 cases were studied, which number is approximately 25.5 per cent of the total number of cases reported in San Francisco for the period under discussion. It may be of interest to note, however, that the number of cases treated in the Isolation Hospital has steadily risen from 26.7 per cent of the total number reported in 1917 to 58.5 per cent in 1937. This may be considered a definite trend toward concentration of such cases in institutions of this character. Of the 3,344 cases, the smallest number occurred under one year, but the percentage case mortality in this group reached 30.8, while the percentage case mortality in the hospital as a whole was approximately eleven. Of the child age group, the case fatality was lowest in the nine-year group, where it was 7.2 per cent. In the adult-age groups, the lowest case fatality was between twenty-five and twenty-nine years, and the rate practically doubled in the cases over thirty years. Diphtheria, therefore, though generally a serious disease, has a higher case fatality in the very young and in the adult groups above thirty years. The case fatality rate for the Isolation Hospital of 11.0 (despite the fact that many cases reach this hospital after several days' illness, and quite often undiagnosed and untreated; in other words, the seriously ill cases), is statistical evidence of its value to the community. The total case fatality for the city as a whole for the period 1917 through 1937, inclusive, was 6.3 per cent of the clinical types of cases treated.

TREATMENT

Of the 3,344 cases treated in the Isolation Hospital, 2,485 were diagnosed as pharyngeal with a percentage fatality of 6.4; laryngeal type, 538, with a percentage fatality of 21.4; nasal type, 185, with a percentage fatality of 20.9; the types of the remaining cases were not stated. Tracheotomy was done on eleven patients, five of whom died. Intubation was performed on 347 patients, when 81 died. There were 484 patients classified with complications of which number 207 died. The clinical complications noted were varied: heart 183, of which 149 died; measles; scarlet fever; nephritis; pneumonia; paralysis of palate; chickenpox; pregnancy; smallpox; syphilis; tuberculosis; vaginitis; whooping cough; and mumps.

Of the 3,344 cases treated in the Isolation Hospital, antitoxin was administered in 3,256. Of the latter number (3,256) antitoxin was administered intravenously in 2,625, with a percentage mortality of 9.3; intramuscularly in 631, with a percentage mortality of 11.7. Of greater interest, however, was the fatality rate taken on the basis of the number of days of illness elapsing before administration of antitoxin. For instance, in 424 cases antitoxin was administered *intravenously* on the first day, with a percentage fatality of 4.6; second day, 574 cases with a rate of 6.6; third day, 485 cases and rate of 10.1; fourth day, 277 cases and rate of 14.8; fifth day, 147 cases and a rate of 16.3; sixth day, 49 cases and a rate of 12.2; and seven days and over, with a rate of 11.1. When antitoxin was administered *intramuscularly,* on the first day, there were 85 cases with a percentage fatality rate of 2.4; second day, 111 cases with a rate of 8.1; third day, 103 cases with a rate of 9.7; fourth day, 77 cases with a rate of 9.1; fifth day, 46 cases with a rate of 13.0; sixth day, 32 cases with a rate of 25.0; and seven days and over, 72 cases with a rate of 16.7. As is to be expected, early diagnosis and early administration of antitoxin is essential if a low case fatality rate for diphtheria is to be maintained. Certainly, the statistical data quoted here are indicative that delay of one or two days in the administration of antitoxin will considerably elevate the fatality rate.

IMMUNIZATION

The effect of immunization on the morbidity and mortality rates for diphtheria has been stressed. It is of decided interest to analyze these data in the 3,344 cases occurring in the period 1917–1937, inclusive. In this number there were recorded sixteen cases that had received either toxin-antitoxin or toxoid. One fatality occurred among the sixteen cases. It could be stated that one clinical case of diphtheria occurred each year in those previously immunized, with the exception of 1918, when two occurred, and 1923, when three occurred. No information was available as to the Schick test in any of the cases.

When the curve of incidence of diphtheria by months in San Francisco is studied, there is noted no complete or definitely appreciable diminution in any month of cases received in the Isolation Hospital. In other words, diphtheria occurs continuously in San Francisco, with elevations of incidence in the fall months, the greatest occurring in December.

IN CONCLUSION

Statistical data are presented for 3,344 cases of diphtheria treated in the Isolation Hospital Division of the San Francisco Hospital of the Department of Health for the years 1917–1937, inclusive. Historically, these data are of interest, since there are facts presented showing the progressive decline of the disease in San Francisco, with information as to immunization against, and as to treatment of cases of diphtheria.

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THE LURE OF MEDICAL HISTORY†

MEDICINE IN COLONIAL AMERICA

By DAVID HARRIS, Ph.D.
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II*

PUBLIC HEALTH DURING COLONIAL DAYS

THE early history of the colonies seems, at times, to be an unbroken record of misery, suffering, and death. Added to natural exposures of pioneering and the menace of hostile Indians were disease and pestilence both old and new. When the first settlers established themselves at Jamestown in the delightful time of early spring, they were pleased with the new place which did "well agree with the English constitucions." But at the end of the summer their joy was gone. George Percy, one of the first settlers, wrote as follows: "Our men were destroyed with cruel diseases, as swellings, flixes, burning fevers, and by wars, and some departed suddenly. But for the most part they died of mere famine. There were never Englishmen left in a foreign country in such misery as we were in this new discovered Virginia. We watched every three nights lying on the bare cold ground, what weather soever came; warded all the next day which brought our men to be most feeble wretches. Our food was but a small can of barley sod in water to five men a day; our drink cold water taken out of the river, which was at flood very salt, at a low tide full of slime and filth, which was the destruction of many of our men. Thus we lived for the space of five months in this miserable distress, not having five able men to man our bulwarks upon any occasion. If it had not pleased God to put a terror in the savage's hearts, we had all perished by those wild and cruel pagans, being in that weak estate as we were; our men night and day groaning in every corner of the fort most pitiful to hear. If there were any conscience in men, it would make their hearts bleed to hear the pitiful murmurings and outcries of our sick men, without relief every night and day for the space of six weeks; some departing out of the world, many times three or four in a night, in the morning their bodies trailled out of their cabins like dogs to be buried."

Not markedly different was the plight of New England. Indeed it seemed as if a pestilence among the Indians had been timed to prepare a place for the bold adventurers, for friendly natives told them of a fatal malady that had raged from 1616 to 1620, almost literally destroying the various tribes in the New England country. The nature of this scourge has never been definitely determined.

Into this devastated region the Pilgrims came in December, 1620. After three months but fifty of the one hundred who landed survived. Bradford believed this high death rate due to their "being Infected with ye Scurvie and other diseases, which this long vioage & their Inacomodate condition had brought upon them; so as there dyed some times 2 or 3 of a day, in ye foresaid time."

Probably the most disastrous journey ever made to the New World was the voyage to Virginia, in 1618, of one hundred eighty emigrants from Amsterdam under the leadership of Francis Blackwell, one of the leading Puritans of the city. Before the small, crowded vessel reached Virginia one hundred thirty people, including Blackwell himself, had fallen victims to disease. The *Lion's Whelp,* the vessel on which William Penn made a "short and speedy" passage of six and one-half weeks, lost thirty from smallpox during the voyage.

Scurvy from time immemorial had been the great scourge of people living on the diet of the sea, taking a dread toll in suffering and death. But after surviving the discomforts and perils of the long sea voyage, and settling in the new country, the immigrants were attacked by many and terrible sieges of disease. These troubles were due largely to the weakened condition in which the people arrived, lack of proper food, rigorous climate, and crowded conditions.

SMALLPOX

One of the worst of the afflictions of the colonies was smallpox. Introduced into the West Indies in 1507 by the Spanish and perhaps later brought to the mainland from other parts of Europe as well, smallpox entered into almost every home of the period at one time or another and demanded its heavy share in the mortality list. Because the disease was so general and unremitting, it seems futile to emphasize any particular date; but the records indicate epidemics of more than usual intensity in 1633, 1666, 1668, 1677, 1688, 1690, 1702, and 1721. The first medical publication in North America was a "Brief Rule to guide the Common People of New England, How to order themselves and theirs in the Small Pocks, or Measles," written in 1777 by Thomas Thacher, a clergyman-physician of Boston.

INOCULATION FOR SMALLPOX

In 1721 Lady Mary Wortley Montagu returned to England from Turkey, bringing with her the story of inoculation for smallpox as it was practiced in Constantinople. The English, as a result of her enthusiasm, were led to experiment on condemned criminals and finally on others.

Cotton Mather, in the colonies, read of this new treatment just six weeks after it was introduced in London, and sought the medical aid of Dr. William Douglass, the one physician of Boston's ten at the time who held a degree; but the idea was too novel for Douglass. Cotton Mather did find an able second, however, in Dr. Zabdiel Boylston, who began the actual work of inoculation in America. His first experiment was done on his own son, a boy of thirteen, and two negro servants; but soon the number had grown to 250, and of this number only six died, while in the same period, of 5,759 who took smallpox in the normal manner 844 died.

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† A Twenty-Five Years Ago column, made up of excerpts from the official journal of the California Medical Association of twenty-five years ago is printed in each issue of CALIFORNIA AND WESTERN MEDICINE. The column is one of the regular features of the Miscellany department, and its page number will be found on the front cover.

* Part I of this series was printed in May, 1939 issue, page 355.

But the persecution that followed the introduction of inoculation is unbelievable. The medical men of the city attacked Boylston as a rash, unscrupulous quack, and the press, led by Benjamin Franklin's brother, declared that death from inoculation was murder; the mobs abused Boylston and the Massachusetts legislature drew up a bill to prohibit this obnoxious practice.

The following is a copy of the resolutions passed by the Justices of Peace and Selectmen, called together by the physicians, as reported by Thomas Hutchinson: "That it appears by numerous instances that inoculation has proved the death of many persons soon after the operation, and brought distempers on many others, which in the end have proved deadly to them. That the natural tendency of infusing such malignant filth in the mass of blood is to corrupt and putrify it, and if there be not a sufficient discharge of that malignity, by the place of incision or elsewhere, it lays a foundation for many dangerous diseases. That the continuing the operation among us is likely to prove of the most dangerous consequences."

This radical departure in inoculating was too astounding for the common people; the medical men were bitter in their criticisms, and the ministers besought the wrath of Jehovah against the wicked who were subverting the decrees of Providence and resisting the punishments of God. In 1732 the Reverend Mr. Massey preached from the text of Job ii:7: "So Satan went forth from the presence of the Lord and smote Job with sore boils from the sole of his foot unto his crown," and concluded that "the cutaneous disease of Job was produced by inoculation from the hands of the devil, and the whole art was of infernal invention." Cotton Mather, as the spirit back of the whole trouble, was abused mercilessly; one opponent carried the antagonism so far as to throw a bomb through his window.

VINDICATION OF COTTON MATHER AND DOCTOR BOYLSTON

But the facts could not be denied. Boylston lost only one patient in forty-eight; the normal ravages of smallpox took one in every seven. The pioneer had finally, by his persistence, vindicated himself, and the storm of condemnation was turned into a hymn of praise. In London he was honored and made a member of the Royal Society. Back in America he retired, secure in fame and fortune.

YELLOW FEVER

Another scourge of the colonies which modern science is banishing from the world was yellow fever. Appearing first in 1647 as the Barbadoes distemper, its epidemics made heavy inroads on the colonists. Quarantines were established, but nevertheless disastrous waves swept over Charlestown and Philadelphia in 1699. Concerning its effects, the Journal of Thomas Story says: "Great was the fear that fell upon all flesh. I saw no lofty or airy countenances, nor heard any vain jesting; but every face gathered paleness, and many hearts were humbled." In 1702 a fearful epidemic in New York drove the Assembly to Long Island, and subsequently it swept various parts of the country at various times.

OTHER DISEASES

But it is wearisome to list the gamut of colonial afflictions. Measles, scarlet fever, diphtheria, dysentery, influenza, and all the rest of the dread horde came and conquered their thousands and slew their ten thousands.

IN THE COLONIAL PERIOD, AMERICA WAS IN THE BACKWASH OF SCIENTIFIC ENDEAVOR

At the beginning of the colonial experience, America scientifically was in the backwash of a world that had hardly broken the shackles of the Age of Faith, and laid her ideas and theories on the altar of scientific procedure. Science can come only when the pioneer has put away his gun and escaped from the plowshare; hence the New World was necessarily far behind the most advanced notions of the day, and constrained to struggle with the decadent theories and rule-of-thumb methods that were being discredited in the centers of civilization. In Europe some of medicine's most brilliant students lived in the sixteenth and seventeenth centuries—one has but to mention Harvey, who discovered the circulation of the blood; but it was impossible that the barber-surgeons, the bone setters, the "practitioners of physick," as well as the parish preacher-doctor and the jack-of-all-trades who served as medical adviser, should have incorporated into their work many new things in science.

GRECIAN CONCEPT OF FOUR ELEMENTS IN THE HUMAN BODY

There still lingered in the popular mind the old notion, handed down from the Greeks, that the human body consisted of four elements, earth, air, fire, and water. In the body were to be found four humors or liquids, bile or choler, blood, melancholy or black bile, and phlegm. Anne Bradstreet (1612-1672), one of the first of New England's poets, expressed this belief in these verses:

> But first they showed their high descent,
> Each eldest daughter to each element;
> Choler was owned by Fire and Blood by Air,
> Earth knew her black swarth child, and Water her fair.

OTHER VAGARIES

Disease, it was commonly believed, came from an excess of one or another of the humors, or from excessive heat or cold or moisture or dryness. It was estimated by one writer in 1603 that eighty thousand diseases could be produced in this manner.

Such a system of thought was responsible for the building up of an elaborate system of drastic cathartics, made drastic because of the necessity for evacuating those humors which "had a depraved way of going wrong and sending up poisonous vapors to the brain, to the injury of those imaginary 'animal spirits.' " The various medicines used were thought to act specifically on the different humors. One type was necessary for phlegm; quite another was needed to dispel the black bile that weighed on the spirits of a hypochondriac.

DOCTRINE OF SIGNATURES

A second strange theory that also had come down through the ages, and which colored professional and lay thought, was the old Doctrine of Signatures. This doctrine was a part of the supernaturalism of the time and an outgrowth of the homocentric conception of the universe. Things had value only in their relation to man. The world was one great pharmacy and God had placed on each substance some cryptic signature to indicate the disease for which it was good. Man's duty was to decipher this label by noting color, odor, form, and other marks. "Like by like is to be cured—that is, similar ulcers by similar forms," said Paracelsus, the renovator of the Doctrine in the Middle Ages. For example, the porus leaves of St. John's-wort which had spots resembling perforations was of obvious value in cases of abrasion, either external or internal. Its illusory appearance of holes left no doubt of its efficacy in cases of hallucination, madness, and assaults of the devil. Such a treatment was called "curing by the assimulate," and along with it was its opposite, "contraries by contraries."

This doctrine had many expressions in America, and its influence is to be found in a number of current prescriptions and methods of healing. Some of the favorite remedies sent by Dr. John Stafford of London to Governor Winthrop of Connecticut serve to illustrate. At times Stafford gave milk as a remedy for jaundice; milk, being white, would attack the black humors. But the treatment suggested to Winthrop was of the "cure by the assimulate" type: "For the yellow Jaundise or Jaunders—Boyle a quart of sweet milke, dissolve therein as much bay-salt, or fine Sal-peter, as shall make it brackish in taste; and putting Saffron in a fine linen clout, rubb it into ye Milke, untill ye Milke be very yellow; and give it ye patient to drinke."

Another: "For paines in ye Brest or Limnes: Weare a Wilde Catts skin on ye place grieved."

STAFFORD'S "BLACK POWDER"

His great prescription, however, and also an example of the old theory, was his "black powder," to which there are many references in the early letters. It was made of toads because toads were poisonous; and since all poison drew poison to itself, this remedy was logically most effective. But because of the warts on the toads, it was to be regarded as an especially valuable treatment in smallpox and other eruption cases.

The "black powder" Stafford prepared as follows:

"In the Month of March, take toads as many as you will find alive; putt them in an earthen pott; so that it may be half full; cover it with a broad tyle or Iron plate; then overwhelme the pott so that the bottom may be uppermost; putt charcoales round about it and over it. . . . Sett it on fire and lett it burne out and extinguish of itself; when it is cold take out the toads; and in an Iron mortar pound them very well." Then came a second cooking which reduced this brown toad powder to harmless animal charcoal, but the good doctor never suspected it. "Moderate the dose," he wrote, "according to the strength of the partie." And he went on with these strange words: "Nota bene. No man can with a good Conscience take a fee or a reward before ye partie receive benefit apparent; and then he is not to demand anything, but what God shall putt into the head of the partie to give him. And he is not to refuse anything that shall be so given, for it comes from God." He closed his letter by adding, "These receipts are all experimented."

MEDICAL PROBLEM OF A "UNIVERSAL REMEDY"

The medical problem which continued to intrigue the popular fancy was the preparation of a universal remedy. From antiquity had come the story of the versatile Mithradates, King of Pontus, who, by experiments on criminals, discovered what medicaments would neutralize all poisons and put these together into his universal antidote, making finally a compound containing more than sixty-five components. Andromachus, physician to Nero, is reputed to have made a slight alteration of the prescription by adding the powdered flesh of the viper, apparently on the principle of curing like by like. During the Middle Ages it was generally called *theriac,* and was known in England usually as Venice treacle. It is interesting to note that this remedy was expelled from the British Pharmacopeia only in the middle of the eighteenth century. In America it was put up in less complicated forms occasionally, and the European viper's rôle was taken by the American rattlesnake.

The Bezoar, or Bezar, stone was another universal remedy in favorable repute. The stone is a mass of hair coated by calcareous salts, and is found in the stomachs and intestines of ruminants. Stones brought from the Orient were held in highest regard, but there arose a definitely established hierarchy in therapeutical value and price, based, obviously, on distance from America. In the East the bezoar was originally worn as an amulet; in America it was powdered for internal use. There is recorded the story of a skillful woman physician of Virginia who, in 1690, gave "pulverized oriental bezoar stone" to a man bitten by a rattlesnake. This remedy was followed by a decoction of dittany, the same in name, at least, as the remedy which Venus applied to the wounds of Aeneas.

This dittany, because of its mythological aura, was a famous "cure" for poisons, for extracting bits of wood or bone from wounds.

But in America its qualities were transferred to the indigenous pennyroyal. Captain Silas Taylor once told a meeting of the Royal Society that in 1657 he had held to the nose of an unwilling rattlesnake some leaves of "wild Pennyroyal" or dittany of Virginia, and the serpent died from its effect in half an hour.

EARLY "CURE-ALLS" IN AMERICA: "RUBILA"

Perhaps we of America find our interest most attracted by the first recorded of the cure-alls originating in America. This remedy was a concoction perfected by John Winthrop, Jr., Governor of Connecticut, and was called by him "Rubila." The ingredients of this famous compound were kept from the public by the use of a secret code which was not deciphered until Oliver Wendell Holmes undertook the task. Some of the ingredients were "four grams of (diaphoretic) antimony with twenty grains of niter with a little salt of tin making rubila." Doctor Holmes believed something was added to redden the powder, as there are references in Winthrop's writings of rubifying or viridating his prescriptions. This was a common practice when the prescriptions appeared too much like plain sugar. The supposition that something was purposely omitted from the written prescription is justified by reference to letters published later in which Winthrop wrote to his son, Wait, that the powder he was sending was not ground enough. Wait, in writing of some rubila of his own preparation, said that it was "not enough ground," "half ground," or "grossly beaten." Elsewhere he wrote: "It is best to make it before the weather be hot." And again: "The dog dayes will not be so good to meddle with rubila in, so it must be deferred at present."

Some idea of the quality and efficacy of rubila might be gleaned from excerpts from Winthrop's correspondence: "Poor little Tome taken yesterday with a great pain in his stomach, belly, and side, like a plurettick feaver; your mother and most of the house up with him all night. He took rubila this morning and hope he is better." One might well suppose, as has been suggested, that the family had to work with him all night, tiring him down, before he could be persuaded to accept the heroic treatment. Further light is shed on this remedy in another letter. A certain Mr. Stone was ill and was advised to take rubila, but the prescriber did not find him "inclinable, though he was burthened in his stomach." From the same letter we find that Governor Newman once took rubila, "but hath not been willing to take it again, nor his wife that he should, though we persuaded and encouraged him thereunto." It is hardly astonishing that Wait Winthrop wrote that "for feaverishness and restlessness" he knew "nothing helps like rubila when there has been strength to bare it."

In still another letter, "poor little Tome's" hesitations appeared to be shared by another sufferer: "For Ashbyes extreemely sweld leggs if he would be persuaded to take rubila in such a proportion as would work with him though the fever be not over and to take it every day for som time, it would insensibly and by degrees take away both the swelling and every evill symptom; he may begin with a grain, or halfe a grain, and so increase halfe a graine every day till it begins to make him a little quamish, and then the next time decrease halfe a grain, and then keep to that proportion."

Relative to taking the medicine we have this letter:

> Guilford June 22, 1655.
>
> Sir, you were pleased to furnish my wife with more cordiall powders by John Crane for Graciana but no directions within or amongst the papers can we find; but truly one of the most needful directions is how to make her willing & apt to take it, for though it seemes very pleasant of itself yet is she grown so marvellous aukward & averse from takeing it in beer. Wherefore I would entreat you to prescribe to us the varyety of wayes in which it may be giuen so effectually; we doubt else it may doe much lesse good, being giuen by force only.

In 1667 John Davenport, pastor at New Haven, wrote that his wife was refractory in taking "pilles" and rubila. "My wife tooke out halfe of one of the papers, but could not beare the taste of it, and is discouraged from takeing any more. I perceive that some speech from yourselfe would best satisfie her, but if God's providence puttes a bar in the way, we are called to submit thereunto." But Governor Haynes was more kindly disposed. In his experience "it wrought very kindly alwaies both causing vomiting and purdginge." Samuel Gorton of Rhode Island was complimentary. "The cordiall and soveraighne powders" had affected him so that he found his body "to be little differing from that which it was before the distemper seized" upon him. He wondered consequently "that a thing so little in quantity, so little in sent, so little in taste, and so little to sence in operation, should beget and bring forth such effects."

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(To be continued)

CLINICAL NOTES AND CASE REPORTS

HELIUM AND OXYGEN MIXTURE

AN ECONOMICAL AND SIMPLE METHOD FOR ITS USE

By Edward Matzger, M.D.
San Francisco

The use of 80 per cent helium and 20 per cent oxygen mixture as a therapeutic gas originated with Dr. A. L. Barach. He reported his findings in the Proceedings of Society for Experimental Biology and Medicine, 32:462, 1934. Subsequently he has reported clinical studies in its use for asthma, pneumonia and cardiac failure, as well as obstructive lesions of the respiratory tract, with satisfactory results.

Its widespread use, however, has been limited, due to two facts. First of all, the apparatus was expensive and required a specially trained person to operate it; and, secondly, the helium was expired into the air, necessitating the use of such large quantities as to make the cost almost prohibitive.

On May 12, 1938, it occurred to me that I could put helium in my basal metabolism apparatus, thereby recirculating it without loss. The use of helium and oxygen mixtures for divers demonstrated clearly that the helium was inert. Using it, therefore, in the closed system of any basal metabolism apparatus having a gas capacity over two liters the helium would remain in the system theoretically with no loss. As a matter of fact, if the patient removes the mask at the end of inspiration there is a loss, but a $3.75 tank of helium will last over a period of many months. I leave in the soda lime and add one part of oxygen for each four parts of helium, and substitute an ordinary anesthetic mask for the usual basal metabolism nose-gag and mouthpiece. In this way the patient, unaided, may use the apparatus when, if, and as he feels the necessity of it, without hazard of helium asphyxiation, because the patient himself controls the inhalation and can remove the mask at will.

As the patient breathes the mixture the total volume diminishes at the rate that oxygen is used up in an ordinary basal metabolism test. The expired carbon dioxid is absorbed by the soda lime, and I find it necessary only to replace oxygen into this system.

I have had many satisfactory results, most frequently in promoting the expectoration of the usually "difficult to raise" sputum. I believe that this technique will find use for many chest diseases.

909 Hyde Street.

CUTANEOUS HISTAMIN REACTION IN DIAGNOSIS OF HYSTERIA

By Max J. Goodman, M.D.
Eureka

OUT of the study of peripheral vascular diseases has come the cutaneous histamin reaction, so useful in diagnosis and prognosis of these conditions, and of such great value in aiding the surgeon to determine the level at which he must amputate an affected limb. When histamin phosphate (1/1000) is injected intracutaneously, the response of the tissues occurs in three stages: first, the trauma of the needle and the contact of the histamin produces a small red area which is immediately (within one minute) masked by a wheal resembling a mosquito bite. This second reaction is due to the irritation of the drug locally and is entirely independent of the nerve supply. It is associated with a change in permeability of the small vessels, allowing fluids to go from the blood into the wheal. Within five minutes after appearance of the wheal a reddened area surrounds it. This is called the arterial flare and is due to capillary dilatation. It is purely a reflex phenomenon, and will occur only if the peripheral sensory-nerve circuit through the dorsal root is intact. If the nerve is sectioned or destroyed by disease, or if the dorsal root is destroyed by a lesion extending from the spinal cord, the arterial flare does not appear, allowing eight days for degeneration of the nerve and loss of reflex arc.

In peripheral vascular disease there is a sensory nerve degeneration which parallels the vascular obliteration, and because of this the test has been useful in determining the extent of the disease. More recently, however, the test has come into use for the diagnosis of traumatic neurosis and hysteria. In addition to the medical value, it may also be useful in medico-legal work because of simplicity of administration, and because there is something which, if shown to a jury of laymen, will mean more than mere verbal expert testimony.

The following case is one in which this test was used to confirm a diagnosis of hysteria:

REPORT OF CASE

The patient, a male, age forty-four, German, married. Occupation, blacksmith. In June, 1937, he sustained a compound fracture of the right tibia and fibula. The external wound healed without infection, and the fractures were well united. He continued to complain of pain over the fracture site, so in February, 1938, an exostosis was removed from the anterior tibial surface at the fracture site. Following this operation, there was some relief of pain. Progress was uneventful until March 28, 1938. While celebrating the purchase of a saloon the patient celebrated too diligently and, in the course of events, sustained an injury to his right upper extremity, including several abrasions on the right hand. On April 4, 1938, suppurative glands in the right axilla were incised and drained. At this time the patient began to show his tendencies by attempting to induce (unsuccessfully) the insurance company to pay for his hospitalization for the care of his arm injury. He made an uneventful recovery from this last injury. On April 29, 1938, his case was closed and he was apparently cured.

On July 18, 1938, he reappeared in our office, stating that he had been having severe pain in his right leg and arm for the past week. This was within a few days after he had unsuccessfully tried to induce the insurance company to reopen his case. Examination at this time showed that motor function in all extremities was good, except for a slight limp in the right leg. There was a coarse tremor in the right hand. Reflexes were normally active. Wassermann was negative. There were no visual disturbances. Eye movements were normal. Eye grounds were normal. Pupils reacted normally. Spinal fluid was negative. Blood pressure, 140/80. An interesting fact, and one not mentioned by the patient, was that there was an anesthesia on the entire right side of the body, excluding the face. The left side of his body was hypersensitive. A diagnosis of hysteria was made.

The patient was checked by the histamin reaction in the following manner: The drug used was histamin phosphate (1/1000). One minim was injected intracutaneously in three places in both lower extremities, one place on both sides of the abdominal wall, and in two places on the upper extremities. The wheal appeared within one minute. About eight minutes later the arterial flare appeared bilaterally in all points of injection except one. This latter was at the site of the original injury and near the operative scar, where we would normally expect some nerve destruction. However, in all other areas, the reaction proved an intact nerve circuit. We know that the patient is not malingering, because with his inability to stand pain he could not have tolerated the severe pain tests to which his affected side was subjected. The test seemed to confirm our diagnosis of hysteria.

COMMENT

When the cutaneous histamin test reacts normally by the formation of its third stage, the arterial flare, we have conclusive evidence that the peripheral sensory nerve to that part is not degenerated. However, the test must be performed after the eight-day period required for nerve degeneration to take place. The reaction is, therefore, of value in differentiating between anesthesias due to organic lesions and hysteria. In conclusion, we wish to emphasize that we do not feel that this test is entirely diagnostic, but that it is an excellent means of confirmation after the diagnosis of hysteria has been established.

SENSITIZATION TO SULFANILAMIDE

REPORT OF CASE

By Robert A. Steven, M.D.
San Francisco

FEVER resulting from a large amount of sulfanilamid, either given in one large dose or repeated smaller doses,[1, 2] has been reported several

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[1] Hageman, P. O., and Blake, Francis G.: A Specific Febrile Reaction to Sulfanilamid, Drug Fever, J. A. M. A., 109:1 (Aug. 28), 1937.

[2] Long, P. H., and Bliss, Eleonar A.: Para-Aminobenzenesulfonamid and Its Derivatives, Arch. Surg., 34:351 (Feb.), 1937.

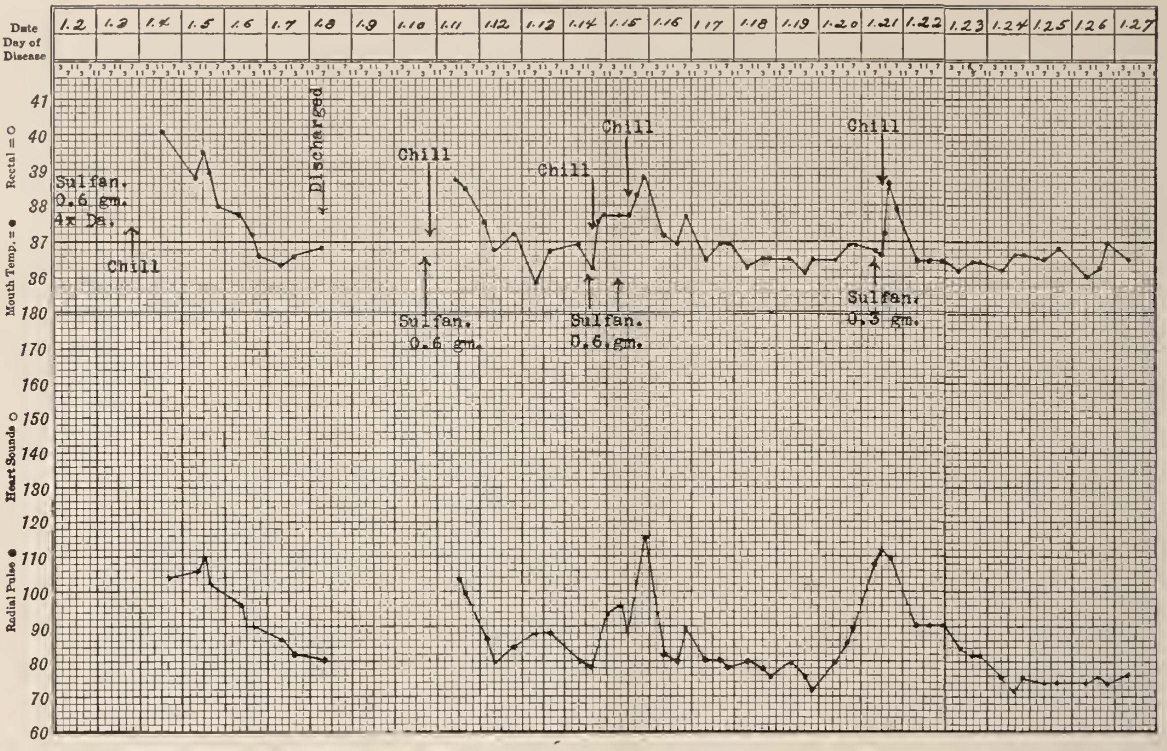

Chart 1.—Graphic record, showing temperature rise after sulfanilamid.

times. When we began to write up this case report, we had been unable to find an instance of chills and fever from a single small dose. More recently, however, Gillette[3] reports: "Sulfanilamid in total dosages, varying from 60 to 420 grains, caused chills and fever in about one per cent of patients. If a patient once developed chills and fever from the drug, small doses would invariably cause reappearance of the symptoms, even when given some five or six days after the sulfanilamid had been discontinued." This coincides exactly with our experience in this case.

REPORT OF CASE

Mr. H. C., married, Polish tailor, age 50, entered on the medical service of the Franklin Hospital on January 4, 1938, complaining of a head cold (one month), muscle and joint pains (three weeks), loss of appetite (three days), and some loss of weight. He denied G. C. Positive physical findings were: Temperature, 104 degrees; appearance flushed and sleepy; very carious teeth; uvula red and edematous; slightly increased splenic dullness and sharp splenic edge palpable one-quarter inch below costal margin. Laboratory reports were: Urine—Albumin, one plus and occasional white blood cells. Blood count—Hemoglobin, 14.2 grams; red blood cells, 4.12; white blood cells, 8,200; polymorphonuclear neutrophils, 68 per cent; lymphocytes, 27 per cent; large monocytes, 5 per cent; blood Wassermann and Kahn negative; blood culture negative; no agglutination of typhoid, Paratyphoid A and B, or melitensis. He recovered rapidly, and was discharged on January 8 with a diagnosis of influenza.

He was readmitted on January 11, when he admitted pertinent facts previously denied. He had contracted gonorrhea four weeks prior to first entry, and had been taking sulfanilamid, .6 gram, four times daily for one week prior to first entry, and on the evening before his first entry he had lost his appetite, had diarrhea, and a definite chill followed by fever. On the day before his second entry, he took one dose of the drug (.6 gram) and two hours later had a chill, felt hot, and had abdominal distress. On entry, temperature was 102 degrees; spleen was somewhat larger; hemoglobin was 11.8 grams, red blood cells, 3.47; white blood cells, 14, 100 with 88 per cent polymorphonuclear neutrophils and 10 per cent lymphocytes; urine showed one to three white blood cells and red blood cells. Patch test with sulfanilamid was negative.

After getting this history we decided, with his permission, to give the patient test doses of sulfanilamid at suitable intervals to determine, if possible, the etiologic rôle of the drug in these reactions. The procedure and results are clearly set forth in the accompanying graphic record. We had intended to proceed further with minute doses, but the patient had to return to work. He had taken no more of the drug and had had no further fever when contacted on July 15.

We believe that the reactions described here are manifestations of an acquired sensitization to sulfanilamid.

384 Post Street.

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[3] Gillette, R. E.: Sulfanilamid: Its Use in Upper Genital Tract Infections in the Female, Calif. and West. Med., 49:3 (Sept.), 1938.

Dangers of Snuff.—Snuff is a primary irritant and causes a burning feeling when first inhaled, *The Journal of the American Medical Association* for May 6 says. Later on, as the habit is formed, the burning feeling is replaced by a sense of exhilaration. When the snuff is inhaled there results, as with the inhalation of all irritating materials, an excess flow of mucus and serum, which is followed immediately by sneezing and blowing of the nose, thus clearing the passages. However, there are three dangers in the use of snuff. In long continued cases there is a tendency to chronic inflammation of the mucous membrane of the nose; polyps (soft, tumor-like growths) seem to occur rather frequently in users of snuff, and because of the excess of sneezing and blowing there is a distinct liability to infection of the sinuses.

BEDSIDE MEDICINE FOR BEDSIDE DOCTORS

An Open Forum for brief discussions of the workaday problems of the bedside doctor. Suggestions of subjects for discussions invited.

REFRACTION

I. PROBLEMS IN REFRACTION

A. Ray Irvine, M.D. (727 West Seventh Street, Los Angeles).—It seems especially fitting to discuss this subject at this time. The so-called "eyesight specialists" and "eye-exercise experts," by means of the radio and newspapers, are constantly broadcasting to the innocent public the dire consequences of neglected eyestrain. Many of them promise to relieve all the troubles and prevent blindness and many diseases, by proper and newer methods of fitting glasses correctly. Others promise, by some sort of electric treatment and muscle exercises, to improve the eyes to the extent that glasses will no longer be necessary. We would be surprised to know how many thousands of people go to one class of advertisers and spend thousands of dollars to have glasses fitted, only to be disappointed and later go to replenish the coffers of the other class by having the glasses removed, and submit themselves to further pocketbook depletion by a series of expensive exercises and light treatments or what-nots. Errors of refraction do not cause any serious pathological conditions. Per contra, pathologic conditions do cause visual disturbances and asthenopic symptoms.

There are a great number of people with pathological conditions who will not be cured by fitting of glasses, and there are an equally great number of people with both pathology and errors of refraction, who should be diagnosed, treated and refracted properly. It seems logical, therefore, that all who have eye symptoms, or visual discomfort or disturbances, should consult a well-trained ophthalmologist in order that the former may not be overlooked or neglected. There are conscientious optometrists who are able to do accurate refractions, but do not recognize pathology. The general practitioner has a special responsibility in this matter, as he realizes the importance of early treatment of eye diseases, while the layman makes no distinction between oculist and optometrist, and often believes that a change of glasses will miraculously eliminate all his symptoms.

The taxpayers' burden to take care of the blind in this state is already in the millions and increasing rapidly. Alleviation of this burden can be attained by early recognition of the disease conditions which cause the blindness.

Visual disturbances may be caused by any of the following: glaucoma, acute and chronic; retinal exudates, hemorrhages, detachments, neoplasms; inflammatory conditions, including optic neuritis and edema of the nerve in intracranial disease; degenerative changes, anemias, diabetes, tuberculosis, syphilis, toxemias, arteriovascular changes in hypertensive disease, lens changes (cataracts and dislocations), pupillary membranes, congenital defects and birth injuries, hemianopsias and quadrant field defects, corneal changes (conus), muscle paresis, squints, etc. Since patients with these conditions often present themselves for refraction, some of the most important will be considered in the following paragraphs.

Of the children with manifest convergent strabismus only 50 per cent can be cured by glasses and exercises. The other 50 per cent can be cured by surgery alone, or surgery combined with exercises and correction of refractive errors. Often the squinting eye is found to be amblyopic, but the vision will improve if a proper correction is worn and the sound eye is occluded. In all these cases a cycloplegic is necessary for accurate examination.

Acquired phorias and squints occurring suddenly in older people may be due to cerebral accidents (hemorrhages). The annoying diplopia may be relieved by prisms in glasses. As the hemorrhages are absorbed, the prisms may be removed. Such patients should be completely examined by an internist.

Blurred vision which comes and goes, burning, fatigue, and sometimes ocular aches, due to accommodation and convergent difficulties, occur in toxemias and metabolic rate changes. When these are corrected, the symptoms disappear. Correction of refractive errors is important, but not sufficient to relieve the patient.

Aching eyes and headaches in frontal and temporal regions, with blurred vision, sometimes watery eyes without inflammatory signs, haloes seen around lights, should always require careful field charts and tension curves, as many early cases of glaucoma may thus be detected. Every oculist sees many such cases, where patients were fitted and refitted with glasses until serious pathologic changes have taken place. Chronic glaucoma is a very common disease and its early recognition is of prime importance to salvage vision and prevent blindness.

Patients come for glasses complaining of severe localized headaches, with nausea at times, dizziness, a feeling of unsteadiness, and a tendency to bump into things on one side. Glasses are changed frequently with no relief. A careful history, an exact perimetry study, fundus examination, and a neurological checkover and general examination, often reveal intracranial tumors. One such case, recalled by the author, revealed a meningioma of the olfactory groove producing pressure on the chiasm with optic nerve and field changes. The vision was restored after surgery. Many such cases are seen by the oculist.

Conical cornea is a condition which frequently occurs in comparatively young people. It may be early detected by frequent changes in astigmatism and increase of myopia. Many times the first symptoms are blurred vision, with history of sudden onset. Keratometer readings are especially important in these cases, inasmuch as early corneal changes may here be easily recognized. Slit-lamp examination may show incipient thinning of the cornea, sometimes with apparent thickening of the corneal nerve fibers. Careful endocrine and metabolic studies should not be overlooked. Treatment other than glasses is indicated. In early cases of conical cornea it is usually possible to obtain useful vision by the use of a strong cylindrical or myopic correction. In more advanced cases of keratoconus, in which the ordinary lenses do not improve the vision, resort to contact lenses may be made.

Time and space will not permit further detailed discussion of the many pathological conditions to be discovered in patients presenting themselves for fitting of glasses.

Besides failure of visual acuity, symptoms accompanying refractive errors include all imaginable manifestations of eye discomfort, from the mildest to the most severe. Among the most common are momentary blurring of vision, doubling of images, annoyance or exhaustion in using the eyes for prolonged work. The eyes may feel tired, strained, hot or uncomfortable, or even painful. Low-grade infections, congestion of the lids and conjunctiva, may accompany eyestrain. Referred symptoms include headaches, dizziness, nausea and even indigestion.

Experience has shown that there is a complete lack of correlation between the number and kind of symptoms, and the number and degree of defects. Given two people with the same refractive error or muscle imbalance, one may have every symptom named above, while the other has none. Likewise, given any of the above symptoms reported by two individuals, one may have practical emmetropia while the other may show some refractive errors. Then, what are we to conclude in regard to asthenopia? First, that symptoms may or may not accompany refractive errors, depending upon the nervous state of the patient, and, second, that the symptoms reported are in no case an indication of what may be wrong.

As for the reasons for eyestrain, the strain comes from the effort to secure clear vision, and when the defect is such as to preclude correction, symptoms are not found. For example, gross errors of refraction and strabismus give less trouble than minor errors and phorias. A certain strain accompanies the dissociation of related functions, such as accommodation and convergence. The hyperope uses accommodation in excess of convergence, the myope uses convergence in excess of accommodation. In anisometropia the correcting effort is unequally distributed to the two eyes. In astigmatism the effort is irregular. Exophoria or deficient convergent power causes extra effort to secure clear binocular vision. Small amounts of hyperphoria are most difficult to correct and frequently cause severe symptoms.

Perfect emmetropia and orthophoria are rare. Small variations from these states are the rule, and minor errors of refraction when accompanied by good vision by no means require correction. Since refraction is an art as well as a science, the oculist must decide in each case what constitutes a minor error or what constitutes a moderate error of refraction. This depends upon the age, physical condition and nervous state of the patient. The neurasthenic patient is most subject to discomfort and suffers from the most numerous and unusual varieties of symptoms. Undoubtedly the largest percentage of asthenopias are due to psychoneuroses, to which the refractive errors are more or less secondary.

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II. HEADACHE AND REFRACTION

S. F. Boyle, M.D. (490 Post Street, San Francisco).—Ocular headaches are those related to the use of the eyes or resulting from disturbance of the physiology of the eyes.

Webb Weeks states that headache due to functional disorder of the visual apparatus is a reflex produced by stimulation of the nasal branch of the fifth cranial nerve, being reflected along other branches of this nerve. Changes in the eyeball are felt as pain in the brow along the branches of supraorbital nerve, and pain felt deep in the skull is reflected along the dural branches of the fifth nerve.

Felton assumes that the delicate network of sympathetic fibres surrounding the vessels in and about the eye, controlling the vasomotor tone, record pressure, edema, and hyperemia, associated with the presence of toxins from body waste, fatigue, perverted metabolism or other sources. These sympathetic fibres, by means of their intercranial connections and through vasomotor disturbances, may accentuate the headache reported by the fifth nerve and its branches.

In the midbrain the trigeminal establishes complex connections with the optic, the eighth and tenth nerves. Regarding the latter, Duke Elder believes that the vagal connections probably account for the cardiac and abdominal disturbances which accompany ocular disease such as glaucoma. Moreover, the low distribution of the ophthalmic division of the fifth nerve explains the frequency of the suboccipital headache in eye diseases, since the great occipital nerve reaches the same level in the cord as the first division of the fifth nerve.

The suboccipital headache of hyperphoria has also been explained on the basis of cervical muscle cramp, really minor degrees of head tilting in an effort to maintain single binocular vision more easily.

It is claimed that from 20 to 60 per cent of headaches are functional; and that 70 per cent or more of the patients who come to ophthalmologists complain of headaches in varying degrees.

Kirshner believes that an etiological lead may be had from the location of headache. He classifies the types of headaches according to their situation. He claims that frontal or supraorbital headache frequently indicates hyperopia; occipital headache points to muscle imbalance; temple pain may mean astigmatism and frontotemporal pain in common in hyperopic astigmatism.

Michaelson's studies indicated that ciliary headache, that is, the headache caused by dysfunction or fatigue of the ciliary body in accommodating or focusing, is the same type of referred pain we find in angina pectoris and cardiac dysfunction.

Complete ophthalmic examination serves a negative function in that it rules out headaches that are not of ocular origin and is useful, at times, in discovering such conditions as glaucoma, optic atrophies, choked discs, hemianopsias and retinitis of albuminuric, diabetic or arteriosclerotic origin.

If the eyes must work against difficulties such as are seen in the hyperopic, or far-sighted person, the continued use of the eyes for near work frequently produces headache. This is especially seen in the presbyope who may tax the accommodative power beyond its natural reserve. The same holds true for the astigmatic patient and symptoms frequently arise in youth during the high school or college days if the eyes are used excessively for study. Although some of these patients will not accept a glass if refracted without drops, the use of a cycloplegic frequently discloses the presence of hyperopia or astigmatism.

Apart from the ciliary type of headache due to excessive accommodation or that caused by cramp of the accommodative apparatus, headaches may arise from impaired motility of the eyes or lack of easy coördination. The occipital headache of hyperphoria, vertical imbalance, has been mentioned, but poor convergence or even weak divergence can produce the sensations of eyestrain frequently manifest in the form of headache.

In convalescence from an illness or in any debilitated state the accommodation may be weakened and continued effort to read may produce headache that can readily be relieved by prescribing glasses. When general health of the patient improves the ciliary muscle regains its tone and the use of the glasses may be discontinued. A similar headache arises from overuse of the eyes combined with lack of outdoor exercise. There are limits of endurance even for an organism such as the ciliary body which, under normal conditions, has excellent reserve power. The headaches of ocular origin are, then, most frequently those associated with hyperopia, astigmatism, presbyopia or muscle imbalance. These can in almost every case be relieved by careful refraction and the prescribing of suitable lenses. There are other cases in which the refractive error may be partially responsible for the complaint of headache, and, although other causes of headache are eliminated, the patient may not be free from symptoms. It is in such cases that the correction of a small refractive error may be necessary before the headache can be completely relieved. A cycloplegic is especially indicated in such cases.

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III. REFRACTION VERSUS GENERAL HEALTH

Samuel V. Abraham, M.D. (3875 Wilshire Boulevard, Los Angeles).—A careful and detailed eye examination is essential to appreciate the part played by the eyes in the production or the exaggeration of any symptoms. In addition, the results of a thorough general examination should be available to the ophthalmologist. Only then can the physician properly stress the deserving factors, and avoid undue emphasis on minor or unrelated factors.

It is important for the eye physician to keep in mind that almost everybody will show an error of refraction when properly examined under cycloplegia.[1] * At birth, almost everyone is hyperopic, less than 1.0 per cent showing any myopia. As the age increases, there is a definite tendency for the hyperopia to decrease and the myopia to increase, along with an increase in the size of the eyeball. The relation of this tendency to the general growth factors is indicated by the gradual increase of the myopia during the growing years, so that by the age of 20, myopia found may be as high as 24.7 per cent. Repeated examinations in the same patients over a period of many years tend to confirm this relationship. This is especially true during the adolescent years. After the twentieth year, the change is ordinarily minimal.

Whether or not an individual will show a myopia as an adult depends not only on the growth factors, but to a considerable degree on heredity. Whether a child will show a high or a low degree of hyperopia or astigmatism depends greatly on the error of refraction in one or both parents. Naturally, the myopia due to normal growth processes will tend to be more frequent in those children who start with lower degrees of hyperopia. Myopia has been shown to be considerably more frequent in the offspring of parents when at least one of them is myopic. When both parents are myopic, the chances for myopia in the child are greatly increased.

The symptoms caused or exaggerated by errors of refraction differ somewhat with the error of refraction. They differ also with the various patients. The same patient may have different symptoms at different times, depending on his general health, occupation, and age. Where uncorrected hyperopia is a factor in the complaints, the symptoms may be headaches, chiefly frontal in character, and difficulty on near use of the eyes or at movies, especially if the patient is ill, or has recently been ill. If the condition remains uncorrected, there is a continuous drain on the nervous energy of the body, with resultant additional complaints of photophobia, tiredness, redness of the eyes, styes, general increased irritability, nervousness, insomnia, nausea, anorexia, malaise, and occasionally, blinking. The headaches may be so severe as to suggest even a brain tumor. In children the headaches may not be the prominent symptom. There may be lack of interest in school work, and psychic disturbances in addition to the above symptoms. In adults, too, psychoneurotic disturbances may be present. The accommodative muscle, being more active in the early years, permits the symptoms of eyestrain to be masked for long periods. It is therefore important, particularly in young children, to do a cycloplegic examination in the presence of any complaints not explained by a thorough physical examination, and even in many of these, when the condition does not yield promptly to general care. It may be possible to help considerably by preserving energy being wasted because of an unsuspected amount of hyperopia. It should always be borne in mind that the psychological problems that may be introduced by the prescribing of glasses must be compensated for by a real need for these glasses. In a child under twelve years of age, for example, a hyperopia under 2.00 diopters may be wasteful of energy, but may still be unrelated to the complaints given. Unless there is evidence of a need for the help to be given by glasses, as in asthenic individuals, etc., 2.00 diopters of hyperopia should not be given major blame for any considerable trouble, in view of the 10 diopters or more of accommodation present in these years. When the amount of hyperopia is high, say over 5.00 diopters, the patient may not make a serious effort to overcome the defect. In these cases the visual acuity is frequently found to be subnormal. The early correction of these cases is imperative to prevent the influence that poor vision and eyestrain may have upon the development of the mind, and upon the general hygiene. The marked improvement in the mentality of these cases following correction of refraction has been demonstrated frequently.

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* References will appear in the reprints.

The symptoms in myopia may be similar to those complained of in hyperopia, especially in early cases. However, in well established cases, the patient's chief complaint is one of poor distance vision. Near vision is good. The patient is frequently overstudious and of sedentary habits. The headaches when present are likely to be occipital or diffuse in character, and not definitely increased by near use of the eyes. There may also be increased photophobia, as the pupils may tend to be more sluggish in their responses. In the growing years there seems to be a definite relation to the general health. . . .

Correction by accommodation of the blurred vision caused by astigmatism is generally considered improbable. However, the constant effort to clear the vision when astigmatism is present, may lead to all the symptoms found in uncorrected hyperopia. The symptoms may be considerably exaggerated. Both distant and near vision may be unsatisfactory. There is frequently an attempt to decrease the size of the palpebral fissure (and thus the pupillary opening) as the blur is thus decreased. Any trauma to the cornea or lens of the eye, or any disease affecting the health of either, may cause a change in the refraction.

In keratoconus the astigmatism is usually irregular in character, becoming more so as the condition advances. Ordinary glasses do not give much help in these conditions. The wearing of contact glasses gives excellent improvement in vision. However, at best contact glasses are far from a desirable solution. . . .

As is well known, the power of accommodation naturally decreases with age. The ability to overcome uncorrected hyperopia becomes less, therefore, with age, and the amount of the error as well as the factors affecting the accommodative ability become increasingly important with age. This fact is of importance even in patients with low degrees of hyperopia or with emmetropia around the fortieth year, as at this time the amount of accommodation in reserve is usually insufficient to assure comfort in near use of the eyes over a prolonged period. (Presbyopia has arrived.)

General conditions, both functional and organic, may affect accommodation. Diphtheria may produce permanent or temporary loss of this function. Focal infections may be factors requiring attention. Local inflammations, due to diabetes, syphilis, tuberculosis, etc., may produce a spasm in accommodation and thus change the refraction of the eye. In some of these cases even atropin does not completely relax this spasm, as indicated objectively by the difficulty in maintaining a dilated pupil. Fatigue, acute or chronic illnesses, convalescence, psychic disturbances, excessive smoking, certain chemicals such as arsenic, etc., may lead to weakness in the activity of the accommodation. There may be an increased irritability of the ciliary muscle due to increased effort to use a weakened function. In the presence of a decreased ability of the ciliary muscle to function, whatever the cause, it becomes increasingly important to give greater attention to low errors of refraction (hyperopia). It may even be desirable to give premature aid to the accommodative function in near use of the eyes. Both these helps may be temporary, and may be found unnecessary when the general health factor responsible is removed. Symptoms of errors of refraction may be present in such cases even when no error is present. . . .

Under certain conditions, such as anisometropia, or antimetropia (in which there is a difference in the refraction of the two eyes), the fusional acts of the eyes are made more difficult, if not impossible. The extra strain involved varies considerably in the individual cases, and may be responsible for many and varied nervous disorders. . . .

The two problems, strabismus and amblyopia, while closely related to the subject of refraction and the general health, require extensive discussion. It is desired here to emphasize that proper and early attention to the refraction is important as a prophylactic measure in the prevention of these two conditions. Early correction of moderate and high errors of refraction is of considerable therapeutic value. In early cases, frequently, no further therapy is required. More important than the refraction in these cases is the general health factor. The frequency with which a parent relates the onset of the strabismus to the previous existence of an illness, emphasizes the importance of this factor. The disturbed progress in the development of a normal fusion, which may result from any weakening condition, is similar to the retardation in the development of other cerebration processes. When the error of refraction and the general health are both factors to be considered, the likelihood of a strabismus is increased. This probably accounts for an increase in the frequency of higher errors of refraction (hyperopia) in the squinters than in the nonsquinters of the same age group. The neuropathic type of individual, in whom one sometimes sees a congenital nystagmus, may be given considerable help by proper early refraction. The high errors of refraction frequently found, together with the elimination of the nystagmus in some cases by glasses alone, justifies considering this mode of therapy at the first opportunity.

The error of refraction may be a considerable factor in determining the general physical and mental condition of the patient. The general physical and mental condition of the patient may be chiefly responsible for the symptoms, or for a precipitation of the symptoms given by the patient. It is not always easy to determine which is the major cause of the symptoms. . . .

Since the refraction findings depend to a considerable extent on the method of examination, it should be emphasized that only complete cycloplegia gives the basic findings. Any modification of the method is a compromise for practical reasons only. Any patient who requires a refraction deserves the most accurate one that we may be able to give him, even though the lack of accuracy may not be detected by the patient. Further, it is desired to point out that the so-called dangers of cycloplegics or mydriatics are far from real. A statistical study of more than 500,000 cases seen and examined with cycloplegics by fifty-one reputable eye men revealed that acute glaucoma may occur in less than 0.022 per cent of cases so treated in those over 30 years of age. Cases of patients under 30 occur with even greater infrequency. In the hands of competent eye physicians, the likelihood of any such complication is very slight, and when it does occur it may logically be interpreted as an indication of the existence of an early glaucoma which otherwise would probably have been neglected.

While no major harm may result from prescribing glasses after careful examination, and in fact some benefit may accrue to the patient from the saving of energy, the emphasis should be on the major trouble. An eye doctor must be more than a refractionist. He must be in a position to evaluate the refraction findings in the light of the complaints and the general findings—in short, he must above all be a physician. The patient must be treated as a patient, not simply as a pair of eyes!

Recent Progress in Treatment of Nervous Diseases Reviewed.—Some conception of the astonishing growth during recent years of specific and effective forms of treatment for diseases of the nervous system is contained in a review of modern methods of treating such diseases by Tracy J. Putnam, M. D., Boston, in *The Journal of the American Medical Association* for May 6.

Pointing out that it has not been many years since neurology was widely considered a purely diagnostic specialty, Doctor Putnam says that "one can look through the pages devoted to nervous diseases in almost any textbook of medicine written before the war and find scarcely a single suggestion of treatment beyond arsenic, strychnin, bromides and electricity, aside from the more obvious indications for surgery.

"It is perhaps natural that pain should be the symptom of disease of nerve tissue which earliest demanded and first received specific relief. The use of opium dates back to prehistoric days and no real substitute for it has ever been found."

From that early treatment of pain Doctor Putnam continues with outlines of some of the many advances made in the field of neurology, from operations interrupting the nerve pathways, their resection or surgical removal, on down to the injection of alcohol into the spinal column.

While scattered "cures" have followed the use of any one of a thousand different remedies for epilepsy, he points out, only a few measures have come to be accepted in modern practice. One of these is the use of bromides (heart and brain depressants). On the whole, the most successful treatment for the majority of patients suffering from convulsions of unknown origin is the use of phenobarbital (a drug having a sedative effect). The drugs at present in use for the treatment of convulsions all were primarily introduced as hypnotics (sleep-producers), and the discovery of their anticonvulsant effect has been rather accidental.

"The recognition of syphilis of the nervous system is a relatively modern feat," Doctor Putnam says. "It was doubtless treated with mercury even before it was recognized. According to F. H. Garrison, M. D., the identity of the man who first introduced mercury into therapeutics (treatment) is unknown. It is probable that, as far as neurosyphilis at least is concerned, its reign is almost over.

"The story of the introduction of arsphenamin by Paul Ehrlich in 1910 is familiar to all (his 605 formula which failed and number 606 which succeeded). As a treatment for neurosyphilis it has largely been replaced by a modification—tryparsamid, first prepared in 1917.

"The use of artificially induced fever in the treatment of neurosyphilis has a long history in the life of one man. Wagner von Jauregg apparently first noticed its effect in dementia paralytica (chronic syphilitic nerve disease of the brain) in 1887 but he dropped the subject and returned to it only during the war. His first brief paper specificaliy recommending the use of malaria was published in 1918. Since then the method has become a standard one.

"A few years later (1921) the use of bismuth was proposed by Sazerac and Levaditi. The salts of this metal have largely taken the place of those of mercury. Up to the close of the war, once neursyphilis was established, there was little hope of arresting its course. At present the majority of early cases can be cured."

Meningitis, next to syphilis, Doctor Putnam points out, is the most common form of infection of the nervous system. The value of spinal puncture in its treatment is not yet fully recognized. A specific antiserum for infections with the meningococcus was introduced by Jochmann in 1906. Although widely used, its value still is in some doubt. In the last two years, synthetic drugs of the type of sulfanilamide have become a standard treatment, which is amazingly effective not only against infections by the meningococcus but against other pyogenic (pus-producing) infections.

"An increasing number of diseases of the nervous system now are being recognized as due to vitamin deficiency," Doctor Putnam states. "Not only 'alcoholic' polyneuritis (inflammation of many nerves at once) but also the characteristic confabulatory (delusional) psychosis often associated with it appear to be due in part to a vitamin deficiency. How effective treatment of these conditions will be remains to be seen. The practical understanding and treatment of nervous and mental diseases still are in an expanding stage."

If you are working indoors all day, using your brain instead of your brawn, remember to take some form of active exercise outdoors every day to balance the indoor activity.—*Hygeia.*

CALIFORNIA MEDICAL ASSOCIATION

This department contains official notices, reports of county society proceedings and other information having to do with the State Association and its component county societies. The copy for the department is submitted by the State Association Secretary, to whom communications for this department should be sent. Rosters of State Association officers and committees and of component county societies and affiliated organizations, are printed in the front advertising section on pages 2, 4 and 6.

CALIFORNIA MEDICAL ASSOCIATION†

CHARLES A. DUKES	President
HARRY H. WILSON	President-Elect
LOWELL S. GOIN	Speaker
KARL L. SCHAUPP	Council Chairman
GEORGE H. KRESS	Secretary-Treasurer

OFFICIAL BUSINESS

ASSOCIATION ACTIVITIES

1. *Official Notice of Special Ten-Dollar Assessment.*
2. *House of Delegates Minutes.*
3. *Council Minutes.*
4. *A. M. A. Annual Session—St. Louis.*

DEPARTMENT OF PUBLIC RELATIONS

1. *How Assemblymen Voted on the Proposed Compulsory Health Law (Assembly Bill 2172).*
2. *Prizes for Scientific Exhibits.*
3. *California Physicians' Service.*

OFFICIAL NOTICE OF SPECIAL TEN-DOLLAR ASSESSMENT

Under date of May 15, 1939, an official notice concerning a special ten-dollar assessment levied on all members of the California Medical Association having the status of active members, was sent to every California Medical Association member. Notices follow:

* * *

(COPY)

CALIFORNIA MEDICAL ASSOCIATION
FOUR FIFTY SUTTER
SAN FRANCISCO

Notice of Special Assessment Levied Pursuant to Direction of House of Delegates, on All Active Members of Association, Payable June 1, 1939

To all Active Members of the California Medical Association:

You will please take notice that the House of Delegates of the California Medical Association at the second meeting of its sixty-eighth regular annual session held Wednesday, May 3, 1939, at the Hotel Del Monte, Del Monte, California, directed the Council to levy, and that pursuant thereto the Council, at its meeting held at the same place May 4, 1939, levied a special assessment upon all active members of the Association in the sum of Ten ($10) Dollars, payable on the first day of June, 1939, or within sixty (60) days thereafter.

The special assessment so levied must, therefore, be paid on or prior to the thirty-first day of July, 1939.

You will please further take notice that failure to pay the special assessment levied by direction of the House of Delegates will, pursuant to resolution adopted by the House of Delegates, result in automatic loss of membership.

In order to facilitate collection and record keeping, please make payment to the secretary of your component county society, because the California Medical Association By-Laws, Chapter X, Section 1(b), stipulate that all dues and assessments must be collected by the secretaries of the component county medical societies. Your county society secretary will forward your special assessment to the office of the Association.

By direction of the Council:

KARL L. SCHAUPP, *Chairman*,
GEORGE H. KRESS, *Secretary*.

Dated: May 15, 1939.

* * *

Explanatory Statement Concerning Notice of Special Assessment Enclosed Herewith

To the Active Members of the California Medical Association:

Enclosed herewith you will find a copy of a notice of a special assessment in the sum of Ten ($10) Dollars, payable June 1, 1939, or within sixty (60) days thereafter.

This assessment was levied by the House of Delegates at Del Monte, California, May 3, 1939. The assessment was contained in a resolution adopted by the House of Delegates providing for the creation of a Committee on Public Education and for the employment of a full-time public relations counsel. The resolution states that the purpose of levying a special assessment is to secure sufficient funds with which to carry on a campaign of public information and education with respect to "public health and welfare."

The resolution of the House of Delegates definitely "earmarked" the funds received under this special assessment as follows: "All moneys collected under this resolution shall be carried in a special fund and used only for the educational purposes contemplated in this resolution." In addition, any moneys remaining in the special fund, after discharge of the Committee on Public Education by the House of Delegates, is to be returned pro rata to the then members of the Association who paid the special assessment.

The resolution specifically directed the Council of the California Medical Association to arrange for the collection of the $10 special assessment.

The chairman of the Council (with the approval of the Council) is directed to appoint five members of the Association to the Committee on Public Education (the House of Delegates named the Speaker and the Chairman of the Council as two additional members). Also, the Council is authorized to levy further special assessments, and is directed to do so if funds are found to be necessary by the Committee on Public Education.

The full text of the resolution adopted by the House of Delegates at the Del Monte annual session on Wednesday, May 3, 1939, is printed below.*

Signed:
THE COUNCIL OF THE
CALIFORNIA MEDICAL ASSOCIATION.

Dated: May 15, 1939.

* * *

RESOLUTION

Adopted by the House of Delegates, May 4, 1939.

WHEREAS, The education of the public and public officials in those things which concern the public health and welfare, the standards of the scientific practice of medicine, must be conducted on a wide basis by those who are most qualified to carry on such an educational program; therefore be it

Resolved, By the House of Delegates of the California Medical Association in annual session at Del Monte, California, May 1-4, 1939, that the Council of the California Medical Association is hereby empowered and directed to create a committee of public education, under the supervision and direction of a committee of seven, to consist of the Chairman of the Council, the Speaker of the House of Delegates, and five members of the California Medical Association, appointed by the Chairman of the Council, with the approval of the Council. Said Committee to employ a full time public relations counsel skilled in public relations work and to carry on a state-wide program of education in matters of public health and welfare, on approval of the Council; and be it further

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† For complete roster of officers, see advertising pages 2, 4, and 6.

* For Resolution No. 6, with action of House of Delegates, see page 437; for Council action, on page 446; for Official Notice, see this page, left column.

Resolved, That the Council of the California Medical Association is hereby empowered and directed to levy on and collect from each and every active member an assessment of ten dollars ($10), payable June 1, 1939. The Council is also empowered and directed to levy such assessment or assessments thereafter, payable monthly as may be necessary to accomplish the objectives of this Committee on Public Education, after due submission of plans, and budget approved by the Council; and be it further

Resolved, That failure to pay any of said assessments within sixty (60) days after the date on which each thereof is payable, shall forfeit the membership of a member, provided that the Council shall have the power to reinstate a member as provided by Chapter II, Section 2, Paragraph (b) of the By-Laws; and be it further

Resolved, That all moneys collected under and pursuant to this resolution shall be carried in a special fund and used only for the educational purposes contemplated in this resolution; and be it further

Resolved, That the only compensation received by members of this committee shall be their actual necessary expenses while on committee business; and be it further

Resolved, That any moneys remaining in this special fund at such time as the House of Delegates shall discharge this committee, and its work discontinued, shall be properly allocated and returned to those members from whom they have been collected.

HOUSE OF DELEGATES MINUTES*

Minutes of the Thirty-Sixth Annual Session of the House of Delegates of the California Medical Association

Held at Hotel Del Monte, Del Monte, California, Monday, May 1, 1939, and Wednesday, May 3, 1939

FIRST MEETING

Monday, May 1, 1939

1. **Call to Order.**—The meeting of the House of Delegates of the California Medical Association was called to order in the Auditorium of the Hotel Del Monte, Del Monte, California, Monday, May 1, 1939, at 8:30 p. m., by Speaker Lowell S. Goin of Los Angeles.

* * *

2. **Announcement of Personnel and Report of Credentials Committee.**—Speaker Goin announced that the Credential Committee was A. A. Morrison, Chairman, Ventura; F. J. Gundry, Kern; and G. W. Walker, Fresno.

Credentials Committee Chairman Morrison reported seventy-three delegates and twenty-three alternates qualified for representation in the House. The report of the Committee was accepted, and the Secretary proceeded to call the roll.

* * *

3. **Announcement of Reference Committees.**—Speaker Goin announced the appointment of the following Reference Committees:

Reference Committee No. 1, Reports of Officers and Standing and Special Committees—R. S. Kneeshaw, Chairman, San Jose; S. J. McClendon, San Diego; and Dorothy Allen, Oakland.

Reference Committee No. 2, Report of the Council and Report of Secretary-Treasurer—L. A. Alesen, Chairman, Los Angeles; Edwin L. Bruck, San Francisco; Lyle G. Crain, Los Angeles.

Reference Committee No. 3, Resolutions, Amendments to the Constitution and By-Laws, and New and Miscellaneous Business—Dewey Powell, Chairman, Stockton; John W. Cline, San Francisco; and William H. Daniels, Los Angeles.

* * *

4. **Sergeants-at-Arms.**—Speaker Goin appointed Roy Hammack and John Cline sergeants-at-arms.

5. **Address of President William W. Roblee.**—President Roblee addressed the House on problems confronting medicine, including legislation and the changing trends of medical practice.

The address of the President was referred to Reference Committee No. 1.

* * *

Report of the Council

6. **Report of the Council.**—Karl L. Schaupp, Chairman of the Council, presented the following as the Council's report to the House of Delegates:

The Council of the California Medical Association begs leave to submit its report on Association activities for the fiscal year May, 1938 to May, 1939, as follows:

Consolidation of the Offices of Secretary-Treasurer and Editor.

The Council, at its annual organization meeting held on Thursday, May 12, 1938, at Pasadena, consolidated the offices of secretary-treasurer and editor, as indicated in the minutes of meetings printed in CALIFORNIA AND WESTERN MEDICINE, November, 1938, on pages 392–400.

State Humane Pound Act.

The proposed Humane Pound Law, which appeared on the November 8, 1938, State election ballots as Initiative Proposition No. 2, was defeated after a very intensive campaign by education.

County Hospital Problems.

During the last year, the Council came to the full realization of the fact that the interests of the State Medical Association are closely related to those of the farmers of the state in many instances. Subcommittees of the Council met with representatives of the Allied Farm groups on numerous occasions. In the exchange of opinion in these joint sessions, it became evident that many problems could be cleared up by better understanding. Our greatest success has been in an increase in mutual understanding and trust.

Hospitalization Plans.

The Intercoast Hospitalization Insurance Association of Sacramento, the Insurance Association of Approved Hospitals of Oakland and San Francisco, and the Associated Hospitals Service of Southern California, with headquarters in Los Angeles, have each rendered pioneer service of great value to their respective sections, and to the Medical Association. They are working with increasing harmony, one with the other, and as a group they are coöperating in the attempt to coördinate medical and hospital service plans of the California Physicians' Service.

Medical Service Plans.

The Council, following the instructions of the House of Delegates on December 17 and 18, carried to a conclusion the organization of the California Physicians' Service for the purpose of making available to the people of California periodic payment for medical service. The first formal report on this project was made this morning by the officers of the California Physicians' Service.

New Tax Assessment Against the California Medical Association and Its Official Journal.

In the Council minutes and in the Pre-Convention Bulletin (page 39), the new taxes levied by Federal and State authorities have been discussed. Payments have been made under protest for the period under question.

Herzstein Bequest—Cancer Exhibit at the Golden Gate International Exposition.

The sum of $5,000 has been allocated from the Herzstein Bequest and has been used to present an exhibit on cancer at the Golden Gate International Exposition.

Postgraduate Activities.

Presentation of Postgraduate education is of necessity limited by the funds available for this purpose. Local Postgraduate Committees are urged to make every effort to promote a good attendance, also to plan ways and means whereby the expenses could be partially shared by the physicians who attend the session.

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* Secretary's Note.—The following is a digest of the stenographic record of both meetings of the House of Delegates. The official and detailed record, as electrically recorded, is on file in the Central Office of the California Medical Association, 450 Sutter Building, San Francisco.

Technical-Commercial Exhibits.

Members of the Association are reminded that the exhibitors in technical-commercial exhibits division have entered their exhibits and paid the Association for the privilege of your attention. Our exhibitors are from among the best-known firms in the United States. It is hoped that the members will extend to them every courtesy to which they are entitled.

Scientific Exhibits.

An innovation in the Scientific Exhibits Division is the arrangement for the presentation of many medical films. It is hoped that the start made this year will lead to a large development of this feature of annual sessions.

Three prizes will be given: First prize, "Award of Special Merit"; second prize, first honorary mention; third prize, second honorary mention. Prizes will be of framed diploma type.

Inyo-Mono Counties Medical Society Charter.

The Council recommends to the House of Delegates that the charter applied for by the newly formed medical society—Inyo-Mono Counties—be granted and that Inyo and Mono counties be removed from the Fourth District allocation and placed in the Second Councilor District.

Membership.

On December 31, 1938, the membership of the California Medical Association was 6,101, which is the largest membership ever attained by this organization.

It is estimated that approximately 85 per cent of eligible doctors of medicine are now members of the Association.

California and Western Medicine.

The monthly issues of the Official Journal carry to the members, no matter how far remote or isolated, with the contributions of their fellows to scientific medicine, the story of the problems organized medicine is being called upon to solve. CALIFORNIA AND WESTERN MEDICINE has given generous space not only to California, but to other medical service plans and has played an important rôle in the efforts to have members of the California Medical Association work unitedly and harmoniously to promote the interests of California Physicians' Service.

County Secretaries' Conference.

As during the last few years the conferences of the secretaries have been held with the officers of the Association, the Council appreciated the effort made by these men in the interests of the members of the Association.

Visitation Tours by the Ranking Officers.

Attention is called to the value accruing to both organized and scientific medicine, through the visitation tours to the component county societies by the President, President-Elect, Councilors, and Association Secretary. Such presentation and exchange of informal opinion make for solidarity and united action from one end of the state to the other.

Woman's Auxiliary.

Appreciation and praise are due the Woman's Auxiliary and its component county units, not only for efficient aid rendered in the antivivisection and other legislative campaigns, but for the increasing influence the members of the Auxiliary are exerting among lay groups and organizations. The Auxiliary is in California to stay.

The Council recommends a vote of thanks to the members of the Woman's Auxiliary in appreciation for their loyal understanding and support.

Financial Problems and Needs:

An inspection of the financial budget of the present, in comparison with that of one or two decades past, reveals at once the increasing number, complexity and seriousness of the problems, organized and scientific medicine are called upon to solve. For instance, the proposed antivivisection act, a proposed law that would almost have wrecked many phases of scientific research in California, and which was defeated by organized medicine, but not without severe drain upon Association funds.

Note also, that the institution of medical service plans, even though on a nonprofit basis and with altruistic background, cannot be brought about except with the expenditure of very considerable sums of money.

Before us, perhaps in the near future, if a special election is called, comes across our paths the proposed Chiropractic Initiative which, if enacted by vote of the people, would give the group an increase in the scope of practice that would practically create a new group, namely, chiropractic physicians and surgeons.

In the Legislature, the naturopaths have again presented statutes that would give legal recognition to their group. In due time, it may be taken for granted that some high pressure publicity group will persuade this group to strive for legal recognition through initiative vote of the people, after the manner of their chiropractic fellows.

Which brings to our attention the need of a basic science law as a desirable means of preventing the enactment of laws, through either the Legislature or by vote of the people, for cultist groups of healing-art practitioners. The Council regrets the unforeseen circumstances that have arisen in different state election years that have prevented it from placing a basic science initiative on the ballot.

With this report is submitted to the House of Delegates a budget for the next fiscal year, which begins at the close of the present sixty-eighth annual session.

Dues.

The Council recommends that the dues for the calendar year 1940, be twenty dollars ($20) per member.

Proposed Budget.

The budget for the calendar year 1940, presented to the Council by the Auditing Committee, has been carefully considered and is herewith submitted to the House of Delegates:

BUDGET*

I. "Estimated" Income

1. Membership dues	$60,000.00
2. Advertising sales	25,000.00
3. Journal subscriptions	800.00
4. Reprint sales	2,500.00
5. Earned interest	250.00
6. Addressograph service	150.00
7. Miscellaneous	5,000.00
Total	$93,700.00

II. Expense Allocations Recommended

8. Rent	$ 3,425.00
9. Telephone and telegrams	750.00
10. Postage	750.00
11. Stationery and printing	1,000.00
12. Office supplies	500.00

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* The budget as first submitted by the Council was based on annual dues of twenty dollars per member. However, the House of Delegates made the annual dues ten dollars per member. Had the twenty dollar dues been adopted, the sum of $60,000 (6,000 members at ten dollars each) would have been added to the "Estimated" Income, the figure then becoming $153,700 instead of $93,700.

In the Expense Allocations recommended, the $60,000 so received was carried under Item 21 (a) for "Unpredictable Needs and Public Policy." The original budget report as above indicated is in the files of the Central Office. To avoid confusion the budget, as finally adopted on the basis of annual dues of ten dollars, is here given.

The special assessment levied by the House of Delegates and due and payable on June 1, 1939, will be kept in a separate fund and be administered by a Special Committee, as outlined in the resolution thereon adopted by the House of Delegates. For resolution, see page 426.

13. Office expense	300.00
14. Salaries: Clerical	9,900.00
a. Social Security, Title 8, Old Age	225.50
15. Salary: Secretary-Treasurer, Director Public Relations	8,000.00
16. Travel Expense:	
a. Officers	1,000.00
b. Council	1,500.00
c. Executive Committee	750.00
d. Secretary	500.00
e. American Medical Association delegates	1,000.00
17. Department of Public Relations	1,000.00
a. Cancer Commission	500.00
18. Council Expense	300.00
19. Postgraduate expense	2,000.00
20. Expense of committees	1,000.00
21. Public policy and legislation	5,000.00
22. Annual session	3,000.00
23. Legal Department:	
a. Retainer	4,000.00
b. Extra fees	300.00
c. Expense	300.00
d. Extra clerical expense	900.00
24. Donations to libraries	3,000.00
25a. "California and Western Medicine" printing	25,000.00
26b. "California and Western Medicine" postage prepaid	1,500.00
27c. Advertising commissions	4,000.00
28d. Discounts, "California and Western Medicine"	250.00
29e. Editor's salary, "California and Western Medicine"	4,000.00
30f. Postage and expense	150.00
31g. Illustrations, "California and Western Medicine"	700.00
32h. Sundries, "California and Western Medicine"	200.00
33i. "California and Western Medicine" sales tax	2,200.00
34j. Addressograph expense	200.00
35. Reprint expense	2,000.00
36. Women's Auxiliary	200.00
37. Miscellaneous	1,000.00
38. UNEXPENDED BALANCE	1,399.50
Total	$93,700.00

Resignation of Dr. J. B. Harris.

I have now to report to you some of the saddest news that we can have in our California Medical Association. I will read to you: "Dear Doctor Schaupp:—After long and deliberate consideration, I hereby submit to you my resignation as councilor-at-large of the California Medical Association. Very truly yours, (Signed) J. B. Harris."

The above completes the report of the Council.

Respectfully submitted,

The Council.

By Karl L. Schaupp, *Chairman.*

Speaker Goin referred the report of the Council to Reference Committee No. 2.

* * *

7. **Report of the Trustees Of The California Medical Association.**—Karl L. Schaupp, President of the Trustees Of The California Medical Association, stated that the report was printed in the Pre-Convention Bulletin. With the consent of the House, the Speaker referred it to Reference Committee No. 2.

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8. **Report of the Auditing Committee.**—T. Henshaw Kelly, Chairman of the Auditing Committee, reported that the report was printed in full in the Pre-Convention Bulletin.

With the consent of the House, the report was referred to Reference Committee No. 1.

* * *

9. **Report of the Legal Department.**—General Counsel Peart directed attention to the formal report of the Legal Department, as printed on page 42 of the Pre-Convention Bulletin, and outlined verbally certain important matters which had received the attention of his department.

Speaker Goin referred the report of the Legal Department to Reference Committee No. 1.

10. **Reports of Committee on Public Relations, and Standing and Special Committees.**—Association Secretary Kress informed the Speaker that all reports of Standing and Special Committees had been published in the Pre-Convention Bulletin.

Speaker Goin, with the consent of the House, referred the reports to Reference Committee No. 1.

* * *

11. **Tribute to Deceased Members.**—At this point the House rose in silent tribute to the seventy-three members of the Association who had died during the past year.

* * *

RESOLUTIONS

12. Introduction of Resolutions.

(a) *A Resolution Amending Article VII, Section 1, of the Constitution.* Introduced by William Voorsanger, San Francisco, for the San Francisco delegation. Resolution follows:

Resolved, That Section 1 of Article VII of the Constitution of this Association, California Medical Association, be and is hereby amended as follows:

By striking out all of the third paragraph of said Section 1 of Article VII, reading as follows:

> "The nine district councilors shall be elected as follows: Prior to the time set for the election of District Councilors, the delegates of each councilor district for which a councilorship is about to become vacant, shall meet, organize and in due form elect one or more members of the said councilor district, as a nominee or nominees for the said vacancy in such councilor district. Such nomination or nominations shall be submitted in writing, signed by at least two delegates who were present at such meeting, and shall be given to the Secretary-Treasurer, by him to be transmitted to the House of Delegates. The House of Delegates may make additional nominations from the floor of the house, and in the event that the delegates from a councilor district fail to submit a nomination or nominations, shall on its own account proceed to make nominations for each district councilor vacancy; and a vote shall then be taken by the House of Delegates to determine who shall be elected to the vacant councilorship."

and by inserting in lieu thereof the following:

> "The nine district councilors shall be elected as follows: Prior to the time set for the election of District Councilors, the delegates of each councilor district for which a councilorship is about to become vacant, shall submit in writing to the Secretary-Treasurer the names of one or more nominees to fill the said vacancy. The Secretary-Treasurer shall transmit the names of such nominee or nominees so submitted to him to the House of Delegates on or before the time set for the election. A vote shall be taken by the House of Delegates upon the nominee or nominees so submitted and, in the event that only one nominee has been submitted, the House of Delegates may, by a majority vote, either elect or refuse to elect said nominee. If the House of Delegates shall reject the sole nominee of the delegates from the councilorship district concerned, then said delegates must immediately thereafter submit an additional nominee or nominees and the House shall proceed to vote thereon; if there is but one nominee, the House may elect or reject. If, after such time as the Speaker may allow, delegates within such councilor district fail to submit an additional nominee or nominees, the House of Delegates may then proceed to make nominations from the floor of the House and a vote shall then be taken by the House of Delegates to determine who shall be elected to the vacant councilorship. All nominees for district councilorships must be members in good standing residing within the district in which the vacancy exists."

Speaker Goin stated that, in accordance with constitutional provision, this amendment to the Constitution would lie over for one year and would be considered at the 1940 session of the House.

* * *

(b) *Resolution No. 1, Survey of Association Offices.* Introduced by William Voorsanger, San Francisco, for the San Francisco Delegation.

Referred to Reference Committee No. 3.

(See page 435.)

(c) *Resolution No. 2, Committee on Standards, Hours, and Compensation for Municipal, County, State, and Federal Medical Employees.* Introduced by William Voorsanger, San Francisco, for the San Francisco delegation.

Referred to Reference Committee No. 3.

(See page 436.)

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(d) *Resolution No. 3, Capitation Systems of Socialized Medicine.* Introduced by William Voorsanger, San Francisco, for the San Francisco delegation.

Referred to Reference Committee No. 3.

(See page 436.)

* * *

(e) *Resolution No. 4, California and Western Medicine Survey.* Introduced by William Voorsanger, San Francisco, for the San Francisco delegation.

Referred to Reference Committee No. 3.

(See page 436.)

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(f) *Resolution No. 5, "Business League" Classification of Association.* Introduced by William Voorsanger, San Francisco, for the San Francisco delegation.

Referred to Reference Committee No. 3.

(See page 436.)

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(g) *Resolution No. 6, Public Relations Counsel and Assessment Therefor.* Introduced by Edwin Bruck, San Francisco, for the San Francisco delegation.

Referred to Reference Committee No. 3. (See also substitute Resolution No. 6, including Resolutions Nos. 6, 8, 12, and 13.)

(See pages 436 and 437.)

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(h) *Resolution No. 7, Code of Ethics.* Introduced by John Hunt Shephard, San Jose, for the Santa Clara delegation.

Referred to Reference Committee No. 3.

(See page 437.)

* * *

(i) *Resolution No. 8, Public Relations Counsel and Assessment Therefor.* Introduced by John Hunt Shephard, San Jose, for the Santa Clara delegation.

Referred to Reference Committee No. 3. (See Substitute Resolution No. 6, including Resolutions Nos. 6, 8, 12, and 13.)

(See page 437.)

* * *

(j) *Resolution No. 9, Nurses' Legislation.* Introduced by Dewey R. Powell, Stockton.

Referred to Reference Committee No. 3.

(See page 438.)

* * *

(k) *Resolution No. 10, Redistricting Inyo and Mono Counties.* Introduced by Joseph B. Stevens of Los Angeles.

Referred to Reference Committee No. 2.

(See page 438.)

* * *

(l) *Resolution No. 11, Relief of Needy Members of Profession.* Introduced by Neil J. Dau, Fresno.

Referred to Reference Committee No. 3.

(See page 438.)

* * *

(m) *Resolution No. 12, Publicity Bureau.* Introduced by G. W. Walker of Fresno.

Referred to Reference Committee No. 3. (See substitute Resolution No. 6, including Resolutions Nos. 6, 8, 12, and 13.)

(See pages 437 and 438.)

(n) *Resolution No. 13, Field Secretary to Carry on Publicity.* Introduced by Samuel Ayres, Jr., Los Angeles.

Referred to Reference Committee No. 3. (See Substitute Resolution No. 6, including Resolutions Nos. 6, 8, 12, and 13.)

(See page 439.)

* * *

(o) *Resolution No. 14, Life Membership.* Introduced by Conrad Brine, Placer.

Referred to Reference Committee No. 2.

(See page 439.)

* * *

(p) *Resolution No. 15, Reservations for Guest Speakers, Delegates, Alternates, and Officers.* Introduced by Chalmers Myers, Los Angeles.

Referred to Reference Committee No. 3.

(See page 439.)

* * *

(q) *Resolution No. 16, Expenses of Officers and Councilors.* Introduced by A. A. Morrison, Santa Paula.

Referred to Reference Committee No. 3.

(See page 439.)

* * *

13. **Approval of Minutes.**—On motion of William Voorsanger, San Francisco, seconded by Eric Larson, Los Angeles, and carried, the President of the Association, the Speaker of the House of Delegates, and the Secretary of the Association were authorized to edit and approve the minutes of the House.

* * *

14. **Meetings of Reference Committees.**—Speaker Goin announced the meeting places of the three Reference Committees.

* * *

15. **Recess.**—At this point the Speaker declared the House in recess until the second meeting, to be held at 4 p. m. on Wednesday, May 3, 1939.

SECOND MEETING

Wednesday, May 3, 1939

1. **Call to Order.**—The House was called to order by Speaker Lowell S. Goin at 4 p. m., Wednesday, May 3, 1939.

* * *

2. **Organization and Roll Call.**—A. A. Morrison, Chairman of the Credentials Committee, reported ninety-four delegates and sixteen alternates qualified to be seated. The Secretary then called the roll and, a quorum being present, the Speaker declared the House duly constituted for the transaction of business.

* * *

3. **Resignation of Vice-Speaker John H. Graves.**—Speaker Goin presented the resignation of John H. Graves of San Francisco as Vice-Speaker of the House of Delegates. On motion of George G. Reinle of Oakland, seconded by Calvert Emmons of Ontario, the resignation of Vice-Speaker John H. Graves was accepted with regret.

* * *

4. **Announcement of Place of 1940 Annual Session.**—The Secretary announced that the Council recommended that the 1940 annual session be held at Hotel del Coronado, Coronado. The recommendation was approved by the House.

* * *

5. **Election of Officers.**

Speaker Goin announced that the next order of business would be election of officers.

(a) *President-Elect.*—Carl R. Howson of Los Angeles nominated Harry H. Wilson of Los Angeles as president-elect. The nomination was seconded by Alson R. Kilgore of San Francisco. There being no further nominations, the Speaker declared the nominations closed. The Secretary cast the ballot of the House for Doctor Wilson. Doctors Vincent Askey and Samuel Ayres of Los Angeles escorted President-Elect Wilson to the platform.

(b) *Speaker of the House of Delegates.* — President Roblee, acting as chairman *pro tem.*, called for nominations for Speaker. S. J. McClendon of San Diego nominated Lowell S. Goin of Los Angeles to succeed himself as Speaker of the House of Delegates. There being no further nominations, President Roblee declared the nominations closed. On motion of T. Henshaw Kelly of San Francisco, seconded by Calvert Emmons of Ontario, the Secretary was instructed to cast the ballot of the House. The Secretary did so cast, and President Roblee announced the election of Lowell S. Goin as Speaker of the House for the ensuing year. Doctor Goin then took the chair.

(c) *Vice-Speaker of the House of Delegates.*—Louis A. Packard of Bakersfield nominated Dewey R. Powell of Stockton as Vice-Speaker of the House of Delegates. The nomination was seconded by A. E. Anderson of Fresno.

Frank W. Ott of Los Angeles nominated Charles Hayes of Los Angeles as Vice-Speaker of the House of Delegates. The nomination was seconded by John W. Cline of San Francisco.

There being no further nominations, the Speaker declared the nominations closed and appointed Russell Lee of Palo Alto and Robert Stone of San Francisco as tellers. A vote by ballot was taken.

Dewey R. Powell of Stockton having received the majority of the votes cast, the Speaker declared him elected Vice-Speaker of the House of Delegates for the ensuing year.

* * *

6. Election of Councilors.

(a) *Councilor for the Second District.*—Samuel Ayres, Jr., of Los Angeles nominated George D. Maner of Los Angeles as councilor for the Second District. The nomination was seconded by T. Henshaw Kelly. There being no further nominations, the Speaker declared the nominations closed. The Secretary cast the ballot, and the Speaker announced the election of George D. Maner as councilor of the Second District for a period of three years; term expiring in 1942.

(b) *Councilor for the Fifth District.*—Secretary Kress stated that he had received written notification that the delegates of the Fifth District had nominated C. Kelly Canelo as councilor. The nomination was seconded by T. H. Kelly of San Francisco. There being no further nominations, the Speaker declared the nominations closed. The Secretary cast the ballot and the Speaker announced the election of C. Kelly Canelo of San Jose as councilor of the Fifth District for a term of three years; term expiring in 1942.

(c) *Councilor for the Eighth District.*—Secretary Kress stated that he had received written notification that the delegates of the Eighth District had nominated Frank A. Macdonald of Sacramento as councilor. The nomination was seconded by T. Henshaw Kelly. There being no further nominations, the Speaker declared the nominations closed. The Secretary cast the ballot, and the Speaker announced the election of Frank A. MacDonald as councilor of the Eighth District for a term of three years; term expiring in 1942.

(d) *Councilors-At-Large.*—Wendell Olson of Fullerton nominated Herbert A. Johnson of Orange County as councilor-at-large to succeed C. C. Tanner, term expiring. Allan Bramkamp of Riverside seconded the nomination.

S. J. McClendon of San Diego nominated C. O. Tanner of San Diego as councilor-at-large. Lyell C. Kinney of San Diego seconded the nomination.

There being no further nominations, the Speaker declared the nominations closed and instructed the tellers to proceed with the ballot of the House. The majority of the votes being cast for C. O. Tanner, the Speaker declared Doctor Tanner elected councilor-at-large for a period of three years; term expiring in 1942.

(e) William Voorsanger of San Francisco nominated Elbridge J. Best of San Francisco as councilor-at-large to succeed T. Henshaw Kelly, term expiring. John Hunt Shephard of San Jose seconded the nomination. There being no further nominations, the Speaker declared the nominations closed. The Secretary cast the ballot of the House, and the Speaker declared Elbridge J. Best elected councilor-at-large for a period of three years; term expiring in 1942.

(f) Junius B. Harris of Sacramento nominated Frederick N. Scatena of Sacramento as councilor-at-large to succeed Junius B. Harris, resigned. The nomination was duly seconded. There being no further nominations, the Speaker declared the nominations closed. The Secretary cast the ballot of the House for Dr. Frederick N. Scatena, and the Speaker announced the election of Frederick N. Scatena as councilor-at-large to fill the unexpired term of J. B. Harris; term expiring in 1940.

* * *

7. Delegates to the American Medical Association.

(a) On nomination of George Reinle of Oakland, seconded by T. Henshaw Kelly, Elbridge J. Best of San Francisco was nominated delegate to the American Medical Association for the sessions of 1940 and 1941, to succeed Elbridge Best, term expiring. There being no further nominations, the Speaker declared the nominations closed. The Secretary cast the ballot of the House, and the Speaker declared Elbridge J. Best elected delegate to the American Medical Association for the sessions of 1940 and 1941.

(b) A. J. Cooper of San Diego nominated Lyell C. Kinney of San Diego as delegate to the American Medical Association for the sessions of 1940 and 1941, to succeed Lyell C. Kinney, term expiring. The nomination was seconded by Irving Ingber of San Francisco. There being no further nominations, the Speaker declared the nominations closed. The Secretary cast the ballot of the House, and the Speaker declared Lyell C. Kinney elected delegate to the American Medical Association for the session of 1940 and 1941.

(c) L. A. Alesen of Los Angeles nominated Lowell S. Goin of Los Angeles as delegate to the American Medical Association for the sessions of 1940 and 1941, to succeed J. P. Nuttall, term expiring. The nomination was seconded by T. Henshaw Kelly of San Francisco. There being no further nominations, President Roblee acting as chairman *pro tem.*, declared the nominations closed. The Secretary cast the ballot, and President Roblee declared Lowell S. Goin of Los Angeles elected delegate to the American Medical Association for the sessions of 1940 and 1941.

* * *

8. Alternates to the American Medical Association.

(a) Zera Bolin of San Francisco nominated Robert S. Stone of San Francisco as alternate to Delegate Elbridge J. Best to the American Medical Association for the sessions of 1940 and 1941, to succeed Robert S. Stone, term expiring. The nomination was seconded by T. Henshaw Kelly. There being no further nominations, the Speaker declared the nominations closed. The Secretary cast the ballot and the Speaker announced the election of Robert

Stone as alternate to Delegate Best to the American Medical Association for the sessions of 1940 and 1941.

(b) F. E. Toomey of San Diego nominated Bon O. Adams of Riverside as alternate to Delegate Kinney to the American Medical Association for the sessions of 1940 and 1941, to succeed Bon O. Adams, term expiring. The nomination was seconded by Lyell C. Kinney. There being no further nominations, the Speaker declared the nominations closed. The Secretary cast the ballot, and the Speaker announced the election of Bon O. Adams as alternate to Delegate Kinney to the American Medical Association for the sessions of 1940 and 1941.

(c) Howard West of Los Angeles nominated Roy E. Thomas of Los Angeles as alternate to Delegate Goin to the American Medical Association for the sessions of 1940 and 1941, to succeed F. M. Pottenger, term expiring. William H. Brownfield of Los Angeles seconded the nomination. There being no further nominations, the Speaker declared the nominations closed. The Secretary cast the ballot, and the Speaker declared Roy E. Thomas of Los Angeles elected alternate to Delegate Goin to the American Medical Association for the sessions of 1940 and 1941.

* * *

9. **Tribute to Retiring Officers.**—At this point the House paid tribute to retiring officers of the Association.

* * *

10. **Standing Committees.**

On request of the Speaker, Secretary Kress read the Council's recommendations on membership of Standing Committees. The House unanimously approved the Council's recommendations for membership. (See advertising page 2 in the Official Journal, for membership of committees.)

* * *

11. **Recess.**—At this point the House recessed until 8 p. m.

* * *

12. **Reconvening of the House.** — The House reconvened at 8 p. m. in the Auditorium of Hotel Del Monte, Wednesday, May 3, 1939.

* * *

13. **Call to Order.**—The Speaker announced that, a quorum being present, the House would proceed with its business.

* * *

14. **Prize Awards for Scientific Exhibits.**—The Association Committee on Scientific Program for the sixty-eighth annual session, through its chairman, Doctor Kress, reported that three awards had been made by a special subcommittee, consisting of three members of the Association, each unknown to the other, who had handed in sealed reports. The joint rating as based upon the reports submitted, gave the first prize, "Award for Special Merit," to the exhibit on "Gastroscopic Studies," which had been presented by Doctors Allan L. Cohn, Alfred White, and Rubin Gold, all of San Francisco, in conjunction with the Mount Zion Hospital of San Francisco.

The second prize, "First Honorary Mention," was awarded to the exhibit on "Gastro-enterostomy and Jejunoplasty Transparencies." This exhibit was contributed by Doctors Carl L. Hoag, John B. Saunders, Harold H. Lindner, and John M. Moore, all of San Francisco.

The third prize, "Award of Second Honorary Mention," was given to the exhibit on "Reconstructive Plastic and Oral Surgery." This exhibit had been presented by Doctors Arthur E. Smith and James B. Johnson of Los Angeles.

REPORT OF REFERENCE COMMITTEE NO. 1

15. **Report of Reference Committee No. 1, Reports of Officers and Standing and Special Committees:**

R. Stanley Kneeshaw, Chairman of the Committee, submitted the following report for his Committee:

To the Speaker and Members of the House of Delegates:

Your Committee on Reports of Officers and Standing and Special Committees,* submits the following report:

The Report of the President.—The California Medical Association has been very fortunate in having a man, as President, who has been so willing to work as Doctor Roblee has been. His long term as Speaker of the House and his close association with the functions of the California Medical Association has fitted him well for the office which he has so ably filled.

Doctor Roblee met with a severe accident which made it difficult for him to visit all of the medical societies this last year, but even under this handicap he was able to visit all of the component societies, familiarizing the men in those districts with the problems of the medical association and promoting a better feeling among the entire membership.

We commend Doctor Roblee for his excellent work in striving to promote this good feeling among the medical profession. We are sorry to see him go—he has been a great leader.

Your Committee recommends the adoption of the President's report. *Carried.*

* * *

Report of President-Elect.—Dr. Charles A. Dukes has ably carried out his duties as president-elect, and we may expect as much or more from him as president.

Your Committee recommends the adoption of the report of the President-Elect. *Carried.*

* * *

Report of the Speaker of the House of Delegates.—Dr. Lowell S. Goin has ably fulfilled his duties as Speaker of the House of Delegates and has rendered efficient service on all of his committee appointments during the year.

We commend Doctor Goin and recommend the adoption of his report. *Carried.*

* * *

Report of the Vice-Speaker of the House of Delegates.—Our able Vice-Speaker, Dr. John H. Graves, has performed his usual duties of vice-chairman in a pleasing manner.

Your Committee moves the adoption of the Vice-Speaker's report. *Carried.*

* * *

Report of the Chairman of the Council.—Dr. Karl L. Schaupp, Chairman of the Council, has been outstanding in the work that he has done this year—his duties have been many and he has fulfilled them all well. His guarding of the finances of the Association is to be commended, as is his work in many fields, which work he has undertaken this year for our benefit.

Your Committee recommends the adoption of the report of the Chairman of the Council. *Carried.*

* * *

Treasurer's Report.—The report of the Treasurer is lengthy and is printed in the *Pre-Convention Bulletin*, as a matter of public record.

Your Committee recommends the perusal of this report by the members of the House of Delegates, so that they may acquaint themselves with the financial standing of the Society. We look with alarm at the increasing expense of the Society each year, particularly the expense of the publication of the CALIFORNIA AND WESTERN MEDICINE, and would suggest a careful analysis of this situation and all other additional expected expenditures, by the Association.

Your Committee recommends the adoption of the Treasurer's report, with the suggestion that a committee be appointed by the Chairman of the Council, to carefully review the status of CALIFORNIA AND WESTERN MEDICINE, with a view of placing it on a more business-like basis.

On motion, this section was laid on the table for later consideration.

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* Committee consisted of R. Stanley Kneeshaw, San Jose; S. J. McClendon, San Diego, and Dorothy Allen, Oakland.

Report of the Secretary.—Your Committee notes with interest and approval, the report of the Secretary, as submitted in the *Pre-Convention Bulletin,* and commends Dr. George H. Kress on the earnest and diversified work that he has done in the past year as Secretary.

Your Committee recommends the adoption of the Secretary's report.

On motion this section was adopted.

* * *

Report of the Editor.—The report of the Editor is a lengthy report and is printed in the *Pre-Convention Bulletin,* and your Committee hopes the members of the House of Delegates will acquaint themselves with the contents thereof.

Your Committee commends Dr. George H. Kress, as Editor, and for carrying out the policies of CALIFORNIA AND WESTERN MEDICINE; however, reiterates the suggestion that the matter of CALIFORNIA AND WESTERN MEDICINE be surveyed by a committee, with the viewpoint of placing it on a better basis financially.

Your Committee recommends the adoption of the report with the suggestion above.

On motion, this section was tabled.

* * *

The Report of the Legal Department.—The Legal Department is to be highly commended on its very able work during the past year, particularly with reference to its work on the case of *Engelking* vs. *Carlson* (*Res Ipsa Loquitur* Case)—also involving corporate practices and legal details of an extremely strenuous nature in connection with the incorporation of California Physicians' Service.

Your Committee recommends the adoption of the report of the Legal Department, as submitted by Hartley F. Peart, General Counsel. *Carried.*

* * *

Reports of the District Councilors.—The reports of the District Councilors give ample evidence that these men have fulfilled their duties well and have given of their time willingly during this last year, especially, due to the added amount of work that the Council has had thrown upon it through the California Physicians' Service—and each Councilor is to be commended.

Your Committee recommends the adoption of the reports of District Councilors. *Carried.*

* * *

Reports of Councilors-at-Large.—Your Committee has noted the reports of the Councilors-at-Large, and note with regret the resignations of Dr. Junius B. Harris and Dr. T. Henshaw Kelly.

Your Committee would suggest that the House of Delegates adopt a resolution commending Doctors Harris and Kelly for their years of service to the California Medical Association, as officers and councilors-at-large.

It is hoped that Doctors Harris and Kelly may see fit, at a later date, to return to the active work which they have so ably been carrying on.

Your Committee recommends the adoption of the reports of the Councilors-At-Large. *Carried.*

* * *

Report of Executive Committee.—The Executive Committee of the Council is to be commended on its excellent work this year, particularly because of the added work that has been thrown upon it because of California Physicians' Service.

Your Committee recommends the adoption of the report of the Executive Committee. *Carried.*

* * *

Report of Auditing Committee.—The Auditing Committee of the Council is to be commended on its work during this year.

Your Committee has noted the report as filed by the Chairman, Dr. T. Henshaw Kelly, and recommends its adoption. *Carried.*

* * *

Report of Committee on Associated Societies and Technical Groups.—The Committee on Associated Societies and Technical Groups is to be commended for their efforts in coördinating the various affiliated societies during the past year.

Your Committee recommends the adoption of the report of the Committee on Associated Societies and Technical Groups, as submitted by the chairman, Dr. John V. Barrow. *Carried.*

* * *

Report of Committee on Health and Public Instruction. The work of this committee, especially with reference to the establishment of a "Pneumonia Control" group in the State, during the past year, is to be commended.

Your Committee notes the rising interest of the medical societies in public education, and strongly urges the continued efforts to establish a Speakers' Bureau in the larger county units of the State, to promote a better understanding on the part of the public, of the work of the medical profession.

Your Committee recommends the adoption of the report as submitted by Dr. Fred B. Clarke, Chairman. *Carried.*

* * *

Report of Committee on History and Obituaries.—This report has been noted.

It is the recommendation of your Committee that the report, as submitted by Dr. Frank R. Makinson, Chairman, be adopted. *Carried.*

* * *

Report of Committee on Hospitals, Dispensaries and Clinics.—This committee did not meet during the past year.

No action taken.

* * *

Report of Committee on Industrial Practice.—This committee is to be commended on its efforts to liberalize and make broader the provisions of the State Compensation Insurance Act, and its efforts to give the working man better service and better medical and surgical care.

Your Committee recommends the adoption of the report of this Committee as submitted by Dr. Philip Stephens, Chairman. *Carried.*

* * *

Report of Committee on Medical Defense.—The work of this committee is to be commended, in view of the fact that an alarming number of malpractice suits are being filed in the State of California.

Your Committee recommends the establishing of a medical defense committee in each component county unit, so that these problems may be properly adjusted.

Your Committee recommends the adoption of the report of the Committee on Medical Defense—with the suggestion as above—Dr. George G. Reinle, Chairman of said committee. *Carried.*

* * *

Report of Committee on Medical Education and Medical Institutions.—This committee has had an active year and is to be commended for its furtherance of postgraduate work in the State.

Your Committee recommends that the report of this committee, as submitted by Dr. L. R. Chandler, Chairman, be accepted. *Carried.*

* * *

Report of Committee on Membership and Organization.—Your Committee commends the Membership Committee on their efforts in obtaining increased membership, so that at the present time the membership stands at an all-time high in the State.

Organized medicine depends on numbers for effectiveness in combating any unfavorable legislation.

Your Committee recommends the adoption of the report as submitted by Dr. George D. Maner, Chairman. *Carried.*

* * *

Report of Committee on Postgraduate Activities.—Your Committee commends this committee on its efforts during the past year, but regrets that the program as outlined by the committee has not been made more readily available to the component county units, and it is hoped that the program will materialize more definitely in the next year.

Your Committee recommends the adoption of the report as submitted by Dr. John C. Ruddock, Chairman. *Carried.*

Report of Committee on Publications.—Your Committee commends the efforts of the Committee on Publications for their efforts during the past year.

Your Committee recommends the adoption of the report as submitted by Dr. Ralph B. Eusden, Chairman. *Carried.*

* * *

Report of Committee on Public Policy and Legislation.—The efforts of this committee are to be especially commended, due to its increased activities during the legislative year.

Your Committee would like to especially commend the Chairman of this Committee, Dr. Junius B. Harris of Sacramento.

Your Committee recommends the adoption of the report as submitted. *Carried.*

* * *

Report of Committee on Public Relations.—The work of this committee has been extremely valuable during the past year, particularly in the campaign against the State Humane Pound Act, which was defeated largely through its efforts.

Your Committee recommends the adoption of the report as submitted by Dr. George G. Reinle, Chairman. *Carried.*

* * *

Report of Committee on Scientific Work.—This committee is to be especially commended on the excellent program which has been made available to the members at this session.

This program has been one of the outstanding ones in the entire history of the organization.

Your Committee recommends the adoption of the report. *Carried.*

* * *

Report of Cancer Commission.—The Cancer Commission is to be commended on its program of clinical conferences at this session, and for its continued efforts in education throughout the state, and its coöperation with the Women's Field Army campaign of the American Society for the control of cancer.

The continuation of such conferences meets with the hearty approval of the membership, and this committee urges the continuation of such conferences. *Carried.*

* * *

Report of Committee on Medical Research.—This committee, under the able leadership of Dr. P. K. Gilman, was largely instrumental in the successful campaign against Proposition No. 2 on the ballot last election, and he and his committee should be especially commended on their efforts.

Your Committee recommends the adoption of this report. *Carried.*

* * *

Report of Committee on Local Arrangements: Annual Session at Del Monte.—The local committee has contributed to make this an enjoyable meeting. We express our appreciation to both the local and central committee members.

Your Committee recommends the adoption of this report as submitted by Dr. Mast Wolfsohn, Chairman. *Carried.*

* * *

Report of Special Committee on Hospitals.—The work of this committee is to be especially commended, particularly in the establishing of a cordial relationship between the Farm Bureau Federations and Allied Groups with the California Medical Association.

Your Committee recommends the adoption of the report of the Committee as submitted by Dr. Louis A. Packard, Chairman. *Carried.*

* * *

Report of Special Committee on Pneumonia Control.—This committee has done commendable work and has been instrumental in the dissemination of much needed knowledge in the State and we urge its continuation.

Your Committee recommends the adoption of the report as submitted by Dr. Roy E. Thomas, Chairman. *Carried.*

Report of Special Committee on Syphilis.—This committee is to be commended on its work in furtherance of the Venereal Disease Control program, administered by the Bureau of Venereal Diseases, of the State Department of Health, and for contributing to the educational program throughout the State, in the control of venereal diseases.

We emphasize the importance of making proper reports, of investigating sources of infection, and a continuation of the work.

Your Committee recommends the adoption of the report as submitted by Dr. Howard Morrow, Chairman. *Carried.*

* * *

Report of Special Committee on a Basic Science Law.—The work of this special Committee on a Basic Science Law, is to be commended, and the need for such legislation should be stressed.

We urge the Council to proceed with a Basic Science Initiative for the next General election.

Your Committee recommends the adoption of the report as submitted. *Carried.*

* * *

Report of Special Committee on Cancer Exhibit at the Golden Gate International Exposition.—Dr. T. Henshaw Kelly, Chairman, and members of the committee, should be commended on the effectiveness of this Cancer Exhibit, as an educational feature, and we feel that the money spent in preparing this exhibit has been well expended. The committee should be complimented on their initiative in establishing the Cancer Exhibit.

We urge that this Cancer Exhibit at the Golden Gate International Exposition be visited and publicized.

Your Committee recommends that the report be adopted. *Carried.*

* * *

Report of Trustees of the California Medical Association.—Your Committee has carefully reviewed the financial statement submitted by the Council, through the Certified Accountants, Ernst & Ernst.

Your Committee moves acceptance of the Auditing Committee report. *Carried.*

Robert Newell of San Francisco moved that the report as a whole, and as amended, be adopted. *Carried.*

* * *

REPORT OF REFERENCE COMMITTEE NO. 2

16. Report of Reference Committee No. 2, Report of the Council and Report of the Secretary-Treasurer.*—

L. A. Alesen, Chairman of the Committee, submitted the following report for his committee:

To the Speaker and House of Delegates:

PREAMBLE: The year just drawing to a close has been one in which the members of the Council, the Secretary-Treasurer and all other officers of the California Medical Association have been unusually alert and active in its behalf. Long-heralded threats of governmental encroachment upon and interference with the practice of medicine in our State have, during this year, materialized into specific legislative proposals having the support of several pressure groups whose sponsorship has been loud and clamorous. The constant desire on the part of the poorly qualified individual to engage in the practice of the healing art and the misdirected and maudlin sympathy of the uninformed have been once more united in an attempt to throttle scientific investigation and treatment through the perennial antivivisection measure.

These emergencies have been ably met by the Council, the Secretary-Treasurer and the other officers of the Association, but their contravention has required skill, time and money. Our officers have generously and effectively given of their skill and time. We, the membership, must show our appreciation and approval of their efforts by a more generous contribution of our personal and financial aid.

Taxes.—Your Committee wishes to place particular emphasis upon the matter of new taxes levied by State and Federal authorities upon the California Medical Association for old age and unemployment insurance. Notwithstanding the fact that the Commissioner of Internal Revenue has previously held the Association to be exempt from certain taxes because of its nature as a nonprofit scientific and educational organization, this, his own, ruling was reversed on September 9, 1938, and the Association was billed for back taxes for the years 1936, 1937 and 1938, together with interest and penalties. This is obviously unsound and unfair. It illustrates most forcefully government by bureaucratic decree instead of government by law, and represents a threat in national life which should be resisted at all costs.

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* Committee consisted of L. A. Alesen, Los Angeles, Chairman; Edwin L. Bruck, San Francisco, and Lyle G. Craig, Los Angeles.

The Committee moved the adoption of this portion of the report. *Carried.*

* * *

Scientific Exhibits.—The scientific exhibits in this session are particularly meritorious. Your Committee feels that this phase of professional activity should be encouraged and increased in the future.

The Committee moved the adoption of this portion of the report. *Carried.*

* * *

Inyo-Mono County Charter.—The recommendation of the Council that the charter requested by the newly formed Inyo-Mono County Medical Society be granted and that these counties be removed from the Fourth Councilor District and placed in the Second District is approved. This action is contemplated by the resolution introduced by Dr. Joseph Stevens; hence, no further action on this resolution is required if the Council's report is adopted as recommended.

The Committee moved the adoption of this portion of the report. *Carried.*

* * *

Financial Problems and Needs.—Under this heading, the Council's report outlines the past drains upon the Treasury caused by efforts to combat legislative proposals inimical to scientific medicine and the public health. It further indicates the necessity for more funds because of definite measures arising in the near future. To make available an emergency fund for this purpose, the Council recommends that the dues for the year 1940 be raised from the current ten-dollar rate to twenty dollars. Your Committee heartily approves of this proposal in principle. It feels, however, that such an increase in dues would not render available the necessary funds during the coming months of this year when such need is sure to arise. It is therefore recommended that the Council be authorized to levy one or more assessments, preferably in amounts not to exceed ten dollars at a time, and the total amount of these assessments not to exceed twenty-five dollars for the coming year, the time and circumstances requiring these assessments to be left to the discretion of the Council. Your Committee further recommends that money so raised shall be placed in a special fund earmarked for public education in the matter of health safeguards.

The Committee moves that, inasmuch as Reference Committee No. 3 has several resolutions dealing with this matter, that this part of the report be tabled and considered in connection with that report. *Tabled.*

* * *

Budget.—The budget as submitted meets with the approval of your Committee with the exception noted in the preceding paragraph, which contemplates retaining the annual dues at the rate of ten dollars per year as present, with the provision for special assessments as required.

The Committee moved that this part of the report be also tabled and considered in connection with the report of Resolutions Committee No. 3. *Tabled.*

* * *

Resignation of Doctor Harris.—The resignation of Dr. Junius B. Harris from the Council of the California Medical Association is received with extreme regret. It will be impossible to fill satisfactorily the place of this man who has served us long and extremely well.

The Committee moved that this part of the report be adopted. *Carried.*

* * *

Life Membership.—The Council's recommendation that a committee be appointed to study the matter of a life membership to be purchased at the age of sixty is approved for passage.

The Committee moves the adoption of this section of the report. *Carried.*

Reports of the Secretary, the Treasurer and the Editor. The reports of the Secretary, the Treasurer and the Editor are concise and self-explanatory. They evidence excellent and painstaking work directed in an intelligent and capable manner in the conduct of the Association's business. The format and literary excellence of CALIFORNIA AND WESTERN MEDICINE have long been matters of favorable nation-wide comment and should continue to be the source of pride and satisfaction on the part of the entire membership.

Your Committee moves the adoption of this section of the report. *Carried.*

* * *

Report of the Trustees of the California Medical Association.—The report of the Trustees reflects the soundness of our Association, as well as the fact that our fiscal affairs have been placed in the hands of able and conscientious leaders.

The Committee moves the adoption of this section of the report. *Carried.*

The Committee moved the adoption of the report as a whole, with the exception of those sections which had been tabled. *Carried.*

* * *

REPORT OF REFERENCE COMMITTEE NO. 3

17. **Report of Reference Committee No. 3, Resolutions, Amendments to the Constitution and By-Laws, and New and Miscellaneous Business.***—Dewey R. Powell, Chairman of the Committee, submitted the following report for his committee.

Your Committee on Resolutions has given careful consideration to the resolutions placed before them. We have consulted, in most instances, with the authors of those resolutions and with other interested delegates and members of the Association, and herewith present for your consideration our report.

(a) *Resolution No. 1, Survey of Association Offices.* Presented by William Voorsanger for the San Francisco delegation:

WHEREAS, The people of California are faced with increasing attempts on the part of certain agitators to foster inadequate and politically dominated type of "health insurance"; and

WHEREAS, It is more important than ever that we, the organized medical profession, maintain an efficient and united approach to the solution of this and kindred problems; and

WHEREAS, The active directing force of the California Medical Association functions through the central offices of the Society (which offices include the secretarial, editorial, and public relations division); be it

Resolved, That a constructive study of the functioning of those offices be prepared for the members of this House, said study to be conducted by a special committee of three, to be appointed by the Speaker of this Session; and be it

Resolved, That a report of this study shall be placed in the hands of the Council as soon as possible (preferably before September, 1939) in order that that body may initiate such changes as are indicated; and be it

Resolved, That a copy of the study and a report of the Council's action thereon shall be printed in the 1940 Pre-Convention Bulletin.

* * *

Comment.—The Committee feels that, in view of the increasing complexity of the Society's business efforts, the many economic and legislative problems confronting medicine, and the multiplicity of activities that fall upon the Central Office, that it is time to consider a careful survey as to whether or not the present structure is sufficient to efficiently carry on these manifold responsibilities.

It seems, therefore, advisable that a committee be appointed to undertake a survey to determine the most efficient set-up, what changes, if any, are necessary to carry on the business of our Association with its public relations contacts in the most modern and efficient manner.

Therefore, we recommend that this resolution do pass. *Carried.*

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* Committee consisted of Dewey R. Powell, Stockton, Chairman; John W. Cline, San Francisco, and William H. Daniel, Los Angeles.

(b) *Resolution No. 2 Committee on Standards, Hours, and Compensation for Municipal, County, State, and Federal Medical Employees.* Presented by William Voorsanger for the San Francisco delegation.

WHEREAS, Municipal, county, state, and federal employed doctors of medicine are inadequately compensated, worked unfair hours, and are subjected to an excessive patient load; and

WHEREAS, These medical employees provide a baseline for the evaluation of medical compensation; therefore be it

Resolved, That a committee be appointed by the Speaker of the House of Delegates of the California Medical Association to investigate the injustice of these services and to recommend proper standards of hours and payments for these works.

* * *

Comment.—The Committee feels that this resolution calls attention to a situation that requires our careful investigation, inasmuch as doctors of medicine are frequently inadequately compensated, and worked unfair hours by various municipal, county, state, and federal agencies. A committee of this House, purely as an investigatory group, should consider what, if any, means could be undertaken by the California Medical Association to improve the hours and payment.

This Committee to report to the Council, who would have sole power to translate such recommendations into action; and the Committee's findings to be published in the Pre-Convention Bulletin.

We recommend that this resolution do pass. *Carried.*

* * *

(c) *Resolution No. 3, Capitation Systems of Socialized Medicine.* Presented by William Voorsanger for the San Francisco delegation.

WHEREAS, We of the organized medical profession recognize that all previous capitation plans have lowered the standard of medical care, reduced individual initiative and introduced political methods into the practice of medicine; be it

Resolved, That the membership of the California Medical Association, hereby goes on record as condemning all such proposals or legislation, and refuses to participate in the capitation system as a means of socializing medicine.

Comment.—The Committee feels that this resolution is a very timely restatement of our position in opposition of any form of capitation plan in the practice of medicine.

We recommend the adoption of this resolution with the deletion of the words "and refuses to participate in the capitation system as a means of socializing medicine."

The resolution will read:

WHEREAS, We of the organized medical profession recognize that all previous capitation plans have lowered the standard of medical care, reduced individual initiative and introduced political methods into the practice of medicine; be it

Resolved, That the membership of the California Medical Association, hereby goes on record as condemning all such proposals or legislation.

Your Committee recommends that this resolution, as amended, do pass. *Carried.*

* * *

(d) *Resolution No. 4,* CALIFORNIA AND WESTERN MEDICINE *Survey.* Presented by William Voorsanger for the San Francisco Delegation.

WHEREAS, California Medical Association is being subjected to increasing demands for the expenditure of money; and

WHEREAS, There must be a limit to the demand made upon the membership of the California Medical Association to furnish more money as dues and assessments; and

WHEREAS, Wise economy is good business policy; and

WHEREAS, The publication CALIFORNIA AND WESTERN MEDICINE costs the Association over $16,000 annually; therefore be it

Resolved, That a committee be appointed by the Speaker of this House of Delegates to study and report to the 1940 Session of the House of Delegates on the question of replacing the present journal, CALIFORNIA AND WESTERN MEDICINE by publishing a Monthly Bulletin for the members and publishing selected scientific papers from those read at the Annual Sessions in one volume to be known as "Proceedings of the California Medical Association for that year; and be it further

Resolved, That a committee be appointed by the Council to be known as the "Editorial Committee," whose duty will be the selection of scientific papers for publication.

Inasmuch as the import of this resolution has been covered by Resolution No. 1, and, having secured the proponent's consent, this resolution is withdrawn. *Withdrawn.*

* * *

(e) *Resolution No. 5, Business League Classification of Association.* Presented by William Voorsanger for the San Francisco delegation.

WHEREAS, Certain government employees have seen fit to arbitrarily rule that a medical organization is a "Business League" and not a Scientific Society, and advice has been given that the California Medical Association acquiesce to this change in status; and

WHEREAS, It is incumbent upon the medical profession to weigh most carefully each decision that has the possibility of lessening the standards of the profession because the highest courts have ruled that the judgment of the court must depend upon the standards set up by a profession; therefore be it

Resolved, That the California Medical Association does not acquiesce to the "Business League" ruling, but insists and stands by the purposes of this Association, according to Article II, Section 1, which can only be changed by a legal amendment, namely, that it is a Scientific and Educational Society; and be it further

Resolved, That the educational activities are not only for the members but particularly for the furthering of the public good and the Public Health and that this fact be widely publicized.

Comment.—The Resolutions Committee is in complete accord with the sentiment expressed in this resolution, and feels very emphatically that our organization is a scientific and educational society, and not a "Business League." However, we believe that we should take extreme care not to embarrass our Council and legal advisers by any uninformed action on this government ruling, and that we can safely leave this matter in their hands in the future.

We, therefore, recommend that this resolution do not pass. *Motion carried. (Resolution not adopted.)*

* * *

(f) *Resolution No. 6, Public Relations Counsel and Assessment Therefor.* Presented by William Bruck of San Francisco.

Inasmuch as four resolutions (No. 6, No. 8, No. 12, and No. 13) all pertain to the same common problem, a Substitute Resolution No. 6 is offered by the Committee, embodying the thoughts outlined in each of the four.

Doctor Bruck's resolution (No. 6) before amendment follows:

WHEREAS, The education of the public in those things which concern the standards of the scientific practice of medicine, and the concomittant facts which concern the economics of medicine, must be conducted on a wide basis by those who are most conversant with the facts at hand to carry on such an educational program through proper channels; therefore be it

Resolved, By the House of Delegates of the California Medical Association in annual session at Del Monte, California, May 1-4, 1939, that the Council of the California Medical Association is hereby instructed to set up a department of public education, which shall consist of a committee from the membership at large of the California Medical Association, and which shall have attached to it, on a full-time pay basis, a proper public relations counsel skilled in public relations work, to carry on a state-wide program of education of the public in matters of the public health and welfare, and in matters of the economics of medicine, through already existing channels, to include the news press, medical press, the agricultural press, the trade press, and other periodical press, as well as radio time, and public address, etc.; and be it further

Resolved, That committee from the membership of the California Medical Association herein created, attach to it a public relations counsel who is conversant with all the above methods of publicity, and who is already well-known to the public at large, in work of this character in order that public attention to the program be assured; and be it further

Resolved, That such pro rata assessment or assessments be made against the members of the California Medical Association to carry on the above widespread program be made by the Council of the California Medical Association, and that all funds obtained by such assessment or assessments be carried in a special fund for the above educational purposes, and for these purposes only.

Note: The resolution above is considered in the Committee's substitute resolution, which follows:

* * *

Substitute Resolution No. 6 (presented by the Committee as a substitute for Resolutions No. 6, No. 8, No. 12, and No. 13, and including amendments passed by the House), follows:

Whereas, The education of the public and public officials in those things which concern the public health and welfare, the standards of the scientific practice of medicine, must be conducted on a wide basis by those who are most qualified to carry on such as educational program; therefore be it

Resolved, By the House of Delegates of the California Medical Association in annual session at Del Monte, California, May 1-4, 1939, that the Council of the California Medical Association is hereby empowered and directed to create a committee of public education, under the supervision and direction of a committee of seven, to consist of the Chairman of the Council, the Speaker of the House of Delegates, and five members of the California Medical Association, appointed by the Chairman of the Council, with the approval of the Council. Said committee to employ a full-time public relations counsel skilled in public relations work and to carry on a state-wide program of education in matters of public health and welfare, on approval of the Council; and be it further

Resolved, That the Council of the California Medical Association is hereby empowered and directed to levy on and collect from each and every active member an assessment of $10, payable June 1, 1939. The Council is also empowered and directed to levy such assessment or assessments thereafter, payable monthly as may be necessary to accomplish the objectives of this Committee on Public Education, after due submission of plans, and budget approved by the Council; and be it further

Resolved, That failure to pay any of said assessments within sixty (60) days after the date on which each thereof is payable, shall forfeit the membership of a member, provided that the Council shall have the power to reinstate a member as provided by Chapter II, Section 2, Paragraph (b) of the By-Laws; and be it further

Resolved, That all moneys collected under and pursuant to this resolution shall be carried in a special fund and used only for the educational purposes contemplated in this resolution; and be it further

Resolved, That the only compensation received by members of this committee shall be their actual necessary expenses while on committee business; and be it further

Resolved, That any moneys remaining in this special fund at such time as the House of Delegates shall discharge this committee, and its work discontinued, shall be properly allocated and returned to those members from whom they have been collected.

Your Committee recommends the adoption of the substitute resolution as amended by the House. *Carried.*

* * *

(g) *Resolution No. 7, Code of Ethics.* Presented by John Hunt Shephard of San Jose for the Santa Clara delegation. The original resolution as presented by the Santa Clara delegation was somewhat cumbersome. It reads as follows:

Resolved, That the Santa Clara County Medical Society reaffirm its action taken March 18, 1935, pursuant to which the House of Delegates of the California Medical Association did at its Yosemite meeting in 1935 enact a resolution; and be it further

Resolved, That, in view of the trends toward rapid change in the economic, political and social relationships of the physician to his colleague, his patient and the public in general, we respectfully request the House of Delegates of the California Medical Association to instruct or create the proper committee or the Council to bring in at the earliest time consistent with well considered action a report for publication to the Association and subsequent adoption by the House of Delegates, setting up for the physician members of this State a restatement of the code of professional relations in the light of the code of ethics of the American Medical Association; and be it further

Resolved, That we request most respectfully that the House of Delegates of the California Medical Association instruct its delegates to the American Medical Association to sponsor a similar restatement of the code of ethics on a national scale, in view of the nation-wide influence of the appearance of physicians on the public platform, in the press, upon the radio and elsewhere; and be it further

Resolved, That delegates from the Santa Clara County Medical Society to the California Medical Association are hereby instructed to offer and actively to support this proposal at the meeting of the House of Delegates at Del Monte.

Above resolution was adopted by unanimous vote of the Santa Clara County Medical Society at its regular meeting held April 19, 1939.

Substitute resolution for that presented by Doctor Shephard of San Jose, and as amended by the Committee, follows:

Resolved, That this House of Delegates instruct its delegates to the House of Delegates of the American Medical Association to use their best efforts to secure the appointment of a committee for the recodification of the Principles of Medical Ethics; and be it further

Resolved, That the Council of the California Medical Association appoint a committee of three members of the California Medical Association to make a restatement of a code of professional relations in all its applications and local conditions in the State of California in conformance with the code of ethics of the American Medical Association.

Your Committee recommends the adoption of this substitute resolution. *Carried.*

* * *

(h) *Resolution No. 8, Public Relations Counsel and Assessment Therefor.* Presented by John Hunt Shephard of San Jose for the Santa Clara delegation.

Original Resolution No. 8 reads:

Preamble: At a regular meeting of the Santa Clara County Medical Society, held on the 19th day of April, 1939, its delegates to the California Medical Association meeting at Del Monte, California, May 1 to 4, 1939, were instructed to introduce the following resolution:

Whereas, Many misinformed individuals, sincere in their belief that society as a whole will be benefited by some form of politically controlled medical service; and

Whereas, Other individuals, envisioning personal preferment in such a system, are aiding in the spreading of such propaganda; and

Whereas, The promise of relief from the unpredictable indeterminate cost of sickness not only strikes a sympathetic cord in the human heart, but has a strong appeal to man's economic instincts; and

Whereas, Legislation, claimed by its sponsors to provide more adequate medical care than is now available to society at large, has been introduced in the last three sessions of the California Legislature, and also in the Congress of the United States; and

Whereas, The vast majority of the medical profession of America is united in the belief that any form of politically dominated medical service will result in the lowering of the standard of such service and greatly retard medical advancement, to the serious detriment of the people; and

Whereas, We believe that through proper enlightenment of the public, the high type of American medical service now available to all who seek it will be maintained, and all threatened attempts to place it under political control will be defeated; therefore be it

Resolved, By the House of Delegates of the California Medical Association, in regular session at Del Monte, California, this 3rd day of May, 1939, that the Council of the California Medical Association be, and is hereby directed and empowered, to inaugurate and establish in the Department of Public Relations, under the supervision of a man thoroughly trained and experienced in publicity salesmanship, a Department of Public Education; and be it further

Resolved, That the Council of the California Medical Association be, and is hereby empowered to levy a per capita installment assessment not to exceed $75 per member, on each and every active member of the California Medical Association for the purpose of defraying the cost of the department created under this resolution.

Action on Resolution No. 8, as presented by Doctor Shephard of San Jose, is covered in Substitute Resolution No. 6, previously noted.

* * *

(i) *Resolution No. 9, Nurses' Legislation.* Presented by Dewey Powell of Stockton.

WHEREAS, The registered nurses of the State of California are sponsoring a bill (A. B. 620) at the present session of the Legislature which aims to establish and maintain adequate standards of nursing training and practice to which all registered nurses must conform; and

WHEREAS, The principles and standards set forth in A. B. 620 are in keeping with professional standards advocated and supported by the California Medical Association and are a protection to the public of this State; and

WHEREAS, This Bill has already been voted "Do Pass" by the Assembly Committee on Medical and Dental Laws, and any further opposition on the part of the California Medical Association through its Legislative Committee would require appearance before the Senate Committee or opposition on the floor of the Assembly; and

WHEREAS, Many county units of the California Medical Association, after careful study of A. B. 620 as amended, have heartily endorsed it; and

WHEREAS, Other bills before the present Legislature are of much more importance to the membership of the California Medical Association, particularly, the compulsory health insurance bill, A. B. 2172, which has been voted out of Assembly Committee with a "Do Pass' recommendation, and which vitally affects the practice of medicine; and

WHEREAS, We need and should have the wholehearted support of all allied professions, and particularly our friends the registered nurses; and

WHEREAS, The public opposition of the California Medical Association expressed through its Legislative Committee is publicized as a lack of solidarity in professional ranks, and gives comfort and solace to all enemies of organized medicine; therefore, be it

Resolved, That this House of Delegates respectfully request the Council of the California Medical Association, through its Legislative Committee, to adjust any remaining differences to the end that the California Medical Association may support and coöperate with the registered nurses of this State in their desire to establish adequate professional standards, through the adoption of A. B. 620.

Comment.—After conference with the Legislative Committee Chairman, it has been ascertained that all points of difference between the viewpoint of our Committee and the Nurses' Association have been adjusted, excepting one important matter which is now under consideration.

Therefore, the proponents of the resolution have withdrawn it, and the Committee so reports.

* * *

(j) *Resolution No. 10, Redistricting Inyo and Mono Counties.* Introduced by J. B. Stevens of Los Angeles.

WHEREAS, We, the Southern Delegation from Riverside, San Diego, Orange, San Bernardino and Los Angeles counties, understand that the Doctors of Medicine of Inyo and Mono counties have made a request to the California Medical Association for a charter as a component county society; and

WHEREAS, The town of Bishop, because of its geographical location, is readily reached from Los Angeles by automobile over excellent highways which are open all winter, and also by motor bus facilities; and

WHEREAS, The City of Los Angeles owns land to a total of 296,286 acres in the two counties; therefore, be it

Resolved, That because of the above mentioned geographical and economic reasons, we, the Delegation of the above named counties, request the House of Delegates of the California Medical Association to include the Inyo-Mono County unit within Councilmanic District Number Two of the California Medical Association, if and when that unit is chartered.

Action on this is covered in the report of Reference Committee No. 2, L. A. Alesen, Chairman, approving Council report recommending redistricting.

(See page 435.)

* * *

(k) *Resolution No. 11, Needy Members of the Profession.* Introduced by N. J. Dau of Fresno.

PREAMBLE: Since sickness, misfortune and old age not infrequently are the causes of want and inability of worthy members of this Society to provide for themselves and dependents the necessities of life, and since such members of our profession would often rather suffer want and privation than humble their pride and ask assistance from government relief agencies, be it hereby

Resolved, FIRST, That each component county society be asked to appoint a committee to visit sick and needy members, and ascertain what assistance they may require and report their findings to the Secretary of the Society;

SECOND, That the Secretary of the County Society be authorized by the governing board of the Society to render such immediate assistance as may be possible from the funds of the Society;

THIRD, That additional funds for this purpose be secured from the membership by voluntary contributions or assessment as may be voted by the Society;

FOURTH, That the President of the California Medical Association appoint a committee of three, *to be known as "Big Brother Committee" (or other suitable name),** and that this committee ascertain as far as possible the number of physicians in need of assistance in the State of California, and devise ways and means to provide for the essential needs of such members, and report, with recommendations for action, to this House of Delegates at the next annual convention; and be it further

Resolved, That the Council of the California Medical Association may, in the interval, receive and distribute voluntary contributions and bequests for any urgent cases of needy members in the interim.

The Council is hereby instructed to establish a fund to be built up by voluntary contributions and bequests, the principal of which shall be held in trust unless otherwise stipulated by the respective donors, and the income from which shall be disbursed for the relief of deserving needy members of the profession under the direction of the Council or such committees as it may designate.

This resolution has a most worthy objective and attempts to solve the problem for relief for sick and needy members of the profession, both through the county medical society and a state-wide organization empowered to receive voluntary contributions and bequests for this purpose.

We recommend that the resolution, with deletion of the words, "to be known as Big Brother Committee (or other suitable name)," be deleted. *Carried as amended.*

* * *

(l) *Resolution No. 12, Publicity Bureau.* Presented by G. W. Walker of Fresno. Original Resolution No. 12 reads:

WHEREAS, Freedom and free institutions are preserved, not in laws, which may be changed, or in constitution which may be abrogated, but rather in public opinion; and

WHEREAS, Propaganda may mislead through misinformation and distort public opinion; and

WHEREAS, It is always the duty of the Medical Profession to endeavor to ward off the foe of the sick, whether the foe be pathogenic organism or otherwise; and

WHEREAS, Our patients' welfare is now threatened by something worse than an ordinary epidemic, that is, the politician being placed in charge of the patient and physician, in a considerable part of our practice thereby threatening a great increase in the cost of the public for medical care, in which only very inferior medical care can be rendered; and

WHEREAS, Propaganda has been employed very extensively by vicious interests; and

WHEREAS, Many well-meaning people may be misguided by this propaganda; now therefore be it

Resolved, By this House of Delegates that the Council of the California Medical Association and the Public Relations Committee thereof; establish a bureau, or special committee of physicians and others, to actively work in every effective manner, to make available speakers to address all lay groups, giving them facts as to what the Medical Profession is doing now, and as to the adequacy of medical care in the free practice of medicine in America, pointing out that now America has the best medical care in the world, and the proud progress of American medicine as compared with results in all political medical care plans, and the efforts of the California Medical Association through the California Physicians' Service, to demonstrate our anxiety to serve all classes of society in the best possible manner, in order that public opinion may be always well informed and able to discriminate between information and misinformation on the subject of medical care. And if the Council deems it practical to employ the use of radio and the press also, to convey this message, whatever expense the Council may sanction, be and is hereby voted by the House of Delegates of the California Medical Association.

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* Italicized words deleted through amendment.

Action on Resolution No. 12 presented by G. W. Walker of Fresno, is covered in Substitute Resolution No. 6, previously noted.

* * *

(m) *Resolution No. 13, Field Secretary to Carry on Publicity.* Presented by Samuel Ayres, Jr., of Los Angeles. Original resolution reads:

WHEREAS, The medical profession from time to time is subjected to adverse publicity by the press, by the radio and by individuals addressing public audiences; and

WHEREAS, Much information is constantly available to be publicized by the press and by the radio and through the medium of individuals addressing public groups, which information would prove a distinct advantage to the public health and the public welfare in educating the people of this State to the value of medicine to them; and

WHEREAS, Today the importance of public opinion is recognized and public opinion is being used by various groups to attain their ends, often to the detriment of the public health and to the public welfare and to the profession of medicine; therefore be it

Resolved, That this House of Delegates request that the Council of the California Medical Association, acting under Section 8, Chapter IV, of the By-laws of the California Medical Association, take immediate steps to employ one or more executive or field secretaries or representatives to engage in such public relations activities as will tend to estop unfavorable publicity and to promote a better understanding of the value of the profession of medicine in the protection of the health of the people of California.

Action on Resolution No. 13, presented by Samuel Ayres of Los Angeles, is covered in the Substitute Resolution No. 6, previously noted.

* * *

(n) *Resolution No. 14, Life Membership.* Introduced by Conrad Briner of Placer.

WHEREAS, Membership in the California Medical Association is a very valuable asset; and

WHEREAS, Many physicians of advanced years, because of gradually decreasing incomes, find it difficult to continue to pay dues; and

WHEREAS, Because of this decreasing income many aged but satisfactory and respected members of the California Medical Association either give up their membership or continue it with increasing difficulty; and

WHEREAS, Some provision should be made so that these elderly members can continue their active affiliation without undue hardships; and

WHEREAS, The establishment of some procedure whereby members of a certain age can purchase life membership in the California Medical Association would solve this problem for many of our older members; therefore be it

Resolved, That this House of Delegates of the California Medical Association express its approval of such a plan for life membership; and be it further

Resolved, That a committee of three members of the California Medical Association, appointed by the Speaker of the House of Delegates, be appointed to study this problem and report back to the House of Delegates at its 1940 meeting, with such provisions and regulations as they, after consultation with legal counsel of the California Medical Association, may deem sufficient to safeguard the interests of the California Medical Association and of the individual members.

As this resolution is covered in a resolution presented by Doctor Alesen's Committee No. 2, the Committee recommends that Resolution No. 14 be withdrawn. *Motion carried, and the resolution was withdrawn.*

* * *

(o) *Resolution No. 15, Reservations for Guest Speakers, Delegates, Alternates, and Officers.* Introduced by Chalmers Myers of Los Angeles. The original resolution reads:

Resolved, That the delegates attending the Convention of the California Medical Association at Del Monte from May 1 to May 4, 1939, do hereby instruct the Secretary of the California Medical Association to make and confirm hotel reservations for all delegates and alternates hereinafter elected to attend future meetings of the California Medical Association; and that upon receipt by the Secretary, of a list of the delegates and alternates from the component counties, he shall immediately notify them in writing giving the location and cost of the hotel accommodations that have been reserved for them.

Also, that the delegates and alternates shall have ten days within which they may accept or reject such selection.

Finally, that no other reservations shall be issued excepting those for guest speakers and general officers until all delegates and alternates desiring to attend conventions shall have been provided with suitable accommodations.

The Committee on Resolutions submits the following amended resolution:

Resolved, That the delegates attending the Convention of the California Medical Association at Del Monte from May 1 to May 4, 1939, do hereby instruct the Secretary of the Medical Association to request the hotel management to give preferential rights in reservations to all delegates and alternates elected by the component county units to attend the Annual Meetings. Upon receipt by the Secretary of the list of delegates and alternates from the component county societies, he shall have the hotel management notify them in writing, giving the cost and location of the hotel accommodations that the delegates and alternates have ten days in which to accept or reject such hotel accommodations.

Also, that no other reservations shall be issued except those of guest speakers and general officers until after the ten-day period of notice given all alternates and delegates attending the Annual Session.

The Committee feels that it is to the interest of business efficiency of the Society and the House of Delegates to have, in so far as possible, the delegates and alternates located at the headquarters hotel and that, inasmuch as these men give of their time and service to the Society, often at a personal sacrifice in missing section meetings and some of the recreational opportunities incident to all convention gatherings, they should at least have the preferential right to avail themselves of securing their reservations at the headquarters hotel.

The Committee recommends that the resolution be adopted.

On motion of Robert Stone, seconded by C. B. Andrews, an amendment striking out all words after the words "on receipt of a list of delegates and alternates" in the first paragraph. *Amendment defeated.*

A vote was then taken on the motion of the Committee that the resolution be adopted. *Motion defeated.*

* * *

(p) *Resolution No. 16, Expenses of Officers and Councilors.* Introduced by A. A. Morrison of Santa Paula.

PREAMBLE: Inasmuch as the scope of work of the officers of the California Medical Association has greatly increased in the past few years, thereby creating a continuously increasing demand on the time and increasing personal expenditures on the part of Councilors, and Officers, and since Councilors and Officers have received no compensation for time lost from their practices and offices, but have donated their time and received no compensation for their personal expenses while on Association business, such as hotels, meals, taxis, etc.; therefore, be it

Resolved, That Chapter IV, Section 1, Paragraph (b) of the By-Laws, be amended to read as follows:

(b) Expenses of Councilors and Officers. Councilors and Officers shall be allowed railroad fare or mileage not exceeding 5 cents a mile, plus an allowance for maintenance expense of ten dollars a day, while absent from their places of residence; (a) in attending association, district, or county society meetings; (b) meetings of committees of the Association; (c) authorized councilor or officer visits to county societies; (d) and otherwise when on official business, authorized or approved by the Council.

Comment.—The Resolution Committee feels the officers of this Association, in giving their time and thought and energy which often entails absence from their offices, should not be expected or compelled to pay necessary expenses of traveling, either by railroad or automobile, or incidental maintenance expenses, with their own funds.

We, therefore, urge that this resolution be adopted to clarify the question of expenses as applying to officers of the California Medical Association engaged in Association business. *Carried.*

The Committee recommends the adoption of the report as a whole, as amended. *Carried.*

* * *

18. Tabled Reports.

It was moved by Henry Garland, duly seconded, that the sections of reports previously tabled be now removed from the table for consideration. *Carried.*

Budget.—L. A. Alesen, Chairman of Committee No. 2, moved for the adoption of the section of the report fixing the annual dues for the year 1940 at $10 per member. *Motion carried.*

* * *

It was moved by Henry Garland, seconded by Elbridge J. Best, that the report of the Secretary-Treasurer (see page 432) and the report of the Editor (see page 433) be removed from the table.

* * *

Report of Secretary-Treasurer.—R. Stanley Kneeshaw then read the section of his report on the report of the Secretary-Treasurer and moved its adoption. An amendment to strike the last paragraph was defeated. A vote on the original motion was taken. *Carried.*

(See page 432.)

* * *

Report of the Editor.—R. Stanley Kneeshaw then read the section of his report on the Editor, and moved its adoption. An amendment to secure an expression from the membership on California and Western Medicine. Amendment defeated. A vote was then taken on the original motion. *Carried.*

(See page 433.)

* * *

19. **Resolution of Appreciation.**—With the consent of the House, Eric Larson of Los Angeles introduced the following resolution:

> Whereas, The California Medical Association has again been privileged to meet at this delightful place; and
>
> Whereas, Such a meeting adds a great deal of work and confusion to the resident members of the Monterey County Medical Society; and
>
> Whereas, In spite of a large number of members of the California Medical Association, these resident members have provided many comforts and a most hearty welcome; therefore be it
>
> *Resolved*, That it is the profound wish of this House of Delegates that sincere thanks be extended to the members of the Monterey County Medical Society, and to the management of the Hotel Del Monte for their many courtesies.

Motion carried.

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20. **Presentation of President.** — Speaker Goin presented the incoming president, Charles A. Dukes, to the House. Doctor Dukes expressed his appreciation of the honor conferred upon him in a fitting manner.

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21. **Presentation of President-Elect.**—President-Elect Dr. Harry H. Wilson was escorted to the platform by Doctors Hayes and Young, and expressed his appreciation and deep sense of responsibility to the House.

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22. **Presentation of Vice-Speaker.** — Vice-Speaker Dewey R. Powell was then presented to the House.

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23. **President's Certificate.**—Ex-President Robert A. Peers of Colfax presented the President's certificate to William W. Roblee of Riverside on his retirement from office.

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24. **Approval of Minutes.**—The President, the Speaker, and the Secretary were authorized to edit and approve the minutes of the House.

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25. **Adjournment.**—There being no further business the House adjourned.

Lowell S. Goin, *Speaker.*
George H. Kress, *Secretary.*

COUNCIL OF THE CALIFORNIA MEDICAL ASSOCIATION

Minutes of the Two Hundred and Seventy-Third (273rd) Meeting of the Council of the California Medical Association

The meeting was held in the Directors' Room, Hotel Del monte, Del Monte, California, Sunday, April 30, 1939, at 8 p. m.

1. **Call to Order.**

The meeting was called to order by Chairman Schaupp, with the following members present: President W. W. Roblee, President-Elect Charles A. Dukes, Past President Howard Morrow, Speaker Lowell S. Goin, Chairman of Council Karl L. Schaupp; Councilors Calvert Emmons, A. E. Anderson, Louis Packard, A. L. Phillips, O. D. Hamlin, F. N. Scatena, H. S. Rogers, Harry H. Wilson, T. Henshaw Kelly, William H. Kiger, C. O. Tanner, P. K. Gilman; Chairman of Public Relations Committee George G. Reinle, Secretary-Editor George H. Kress; General Counsel Hartley F. Peart and his associate, Mr. Howard Hassard.

Absent: Doctors Harris and Howson.

2. **Resignation of Councilor Harris.**

Chairman Schaupp submitted to the Council the formal resignation of Dr. J. B. Harris, and a personal communication giving as his reasons the desire to devote more time to his practice and his family.

It was moved by William W. Roblee, seconded by C. A. Dukes, that the resignation of Junius B. Harris as councilor-at-large be accepted, and that the Council, in expressing its deep regret that the action is necessary, place on record its own and the Association's keen appreciation of Doctor Harris's invaluable service to organized and scientific medicine in California. Carried.

The Council agreed that the resignation of Doctor Harris should be submitted to the House of Delegates by Doctor Schaupp on Monday evening, with the Report of the Council.

3. **Minutes of the Council.**

The minutes of the 272nd meeting of the Council, held February 25, 1939, as published in the April issue of California and Western Medicine, were approved.

4. **Report of Council.**

The report of the Council, as prepared by Chairman Schaupp, was submitted to the Council for discussion.

The report was considered, section by section, and some minor changes in phraseology made.

5. **Charter Application from Inyo-Mono County.**

Consideration was given to the petition, with copies of by-laws, of a newly formed medical society in Inyo-Mono counties, in which request for a charter as a component county society of the California Medical Association was made.

It was pointed out that at the present time these counties were designated as part of the Fourth Councilor District, and that from the standpoint of accessibility they should be in the Second District.

It was moved by Charles Dukes, seconded by Louis Packard, that the counties of Mono and Inyo be removed from the Fourth District allocation and placed in the Second District. Carried.

It was voted to recommend to the House of Delegates that a charter be granted to the Inyo-Mono County Medical Society.

6. **Annual Dues.**

Consideration was given to the amount of the annual dues to be recommended by the Council to the House of Delegates for the year 1940.

It was moved by William Roblee, seconded by Louis Packard, that the annual dues for the calendar year 1940 be set at twenty dollars ($20) per year per member. A vote was taken, and the motion carried; Doctors Kelly and Phillips voting in the negative.

It was moved by P. K. Gilman, seconded by C. A. Dukes, that the motion fixing the dues at $20 be reconsidered. Motion to reconsider carried.

After further discussion, it was moved by Henry Rogers, seconded by A. L. Phillips, that a special committee be appointed to consider the amount of the annual dues, and submit a report to the Council at its meeting on Monday. Motion carried. The Chairman appointed Doctors William Roblee (Chairman), Harry Wilson, and Louis A. Packard.

Chairman Schaupp stated that the report of the Council would be revised to include the suggestions of the Council, and resubmitted at the Monday meeting.

7. Committees of House of Delegates.

Speaker Goin stated that the Credentials Committee and the three Reference Committees of the House of Delegates would be composed of the following members:

COMMITTEE ON CREDENTIALS

A. A. Morrison (Chairman)	Ventura
F. J. Gundry	Kern
G. W. Walker	Fresno

COMMITTEE ON REPORTS OF OFFICERS AND STANDING AND SPECIAL COMMITTEES

R. S. Kneeshaw (Chairman)	San Jose
S. J. McClendon	San Diego
Dorothy Allen	Oakland

COMMITTEE ON REPORT OF THE COUNCIL AND REPORT OF THE SECRETARY-TREASURER

L. A. Alesen (Chairman)	Los Angeles
Edwin L. Bruck	San Francisco
Lyle G. Craig	Los Angeles

COMMITTEE ON RESOLUTIONS, AMENDMENTS TO THE CONSTITUTION AND BY-LAWS AND NEW AND MISCELLANEOUS BUSINESS

Dewey Powell (Chairman)	Stockton
John W. Cline	San Francisco
William H. Daniels	Los Angeles

8. Review of Medical Service Policies.

Discussion was had of Resolution No. 5, presented at the special session of the House of Delegates on December 17, regarding the review of hospital and medical service plans of commercial companies. Attention was called to the fact that a special committee had been appointed by the Council for this purpose. The Committee reported that, because of the extensive task assigned to it by the resolution of the House of Delegates, it had not as yet progressed sufficiently to prepare or submit a report.

It was moved by Lowell S. Goin, seconded by C. A. Dukes, that the resolution be left on the table. Carried.

9. Membership of Standing and Special Committees.

The Chairman appointed Doctors Henry Rogers (Chairman), P. K. Gilman and C. O. Tanner to act as a special committee to review the membership of the Standing and Special Committees of the Association, and report to the Council with recommendations concerning the vacancies thereon; the Council then to act thereon, and submit its recommendations to the House of Delegates on Wednesday, May 3.

10. Policies of the Association.

Discussion was had of the resolution adopted at the 1938 meeting of the House of Delegates relating to a committee to outline general policies of the Association.

George G. Reinle, Chairman of a Special Council Committee to take up this work, stated that the Committee felt that the matters of policy contemplated in the resolution dealt largely with legislation, and that the consideration of such was largely a function of the Standing Committee on Public Policy and Legislation. On that account, it seemed undesirable to have pronouncements go out from different bodies representing the Association. The delicacy of certain legislative matters that were pending was stressed, and it was pointed out that confusion could easily arise if authority was divided in these matters. It was agreed that, for the present, it was desirable that this procedure should be followed.

11. Active Membership.

The question of interpretation of "Active Membership," in relation to quotas of members in the House of Delegates, was brought up by the Association Secretary.

On motion duly made, seconded and carried, it was

Resolved, That "active members" for the purpose of selecting delegates shall include those members whose membership dues have been paid to the California Medical Association for the current year.

12. Dues for Six Months' Period.

It was moved by Louis Packard, seconded by Henry Rogers, that new members joining the California Medical Association on or after July 1 of any calendar year be assessed only one-half of the yearly dues. Carried.

13. Transfer of Members Prior to April 1.

It was the sense of the Council that members transferring from one component county society to another within the state retained their membership until April 1 (date of delinquency provided in By-Laws, Chapter II, Section 2 (b)), but that final action on acceptance of the transfer rests with the component county society.

14. Retired Members.

The Secretary was instructed to write to the Judicial Council of the American Medical Association and request a decision on the status of retired members of the California Medical Association in the American Medical Association.

15. Section on Industrial Medicine and Surgery.

A request for a change of name of the Section on Industrial Medicine and Surgery to the Section on Traumatic Medicine and Surgery was presented.

It was moved by T. Henshaw Kelly, seconded by Louis Packard, that if the Section presented a resolution to that effect to the House of Delegates, that the Council approve the request for the change in name of the Section on Industrial Medicine and Surgery to the "Section on Traumatic Medicine and Surgery." Carried.

16. Amendment to the By-Laws of the Woman's Auxiliary.

A proposed amendment to Section 1 of the By-Laws re the Nominating Committee was presented for consideration and approval.

It was pointed out that, because the necessary time had not elapsed since publication of the by-law, it could not be considered by the Council or be adopted by the Woman's Auxiliary at the 1939 annual session without a violation of the By-Laws of the Auxiliary. The Association Secretary to so inform the representatives of the Woman's Auxiliary.

17. Financial Statements.

The Secretary presented members of the Council with financial statements covering the calendar year 1938, for the months of March, 1939 and April, 1939.

18. Budget.

The budget of receipts and disbursements for the year 1939–1940 was presented and discussed, and it was agreed that, after consideration by the Special Committee on Dues and report thereon to the Council, it should be submitted to the House of Delegates by the Chairman of the Council in connection with the Council report.

19. Fiscal Year.

It was moved by T. Henshaw Kelly, seconded by Louis Packard, that a committee of the Council be appointed to study the matter of reorganizing the financial set-up of the California Medical Association so that a definite fiscal year shall be established, and that the committee bring in its recommendations before the 1940 session of the Association, in ample time for consideration by the Council, in order that necessary amendments to the Constitution and By-Laws, to bring the recommendations of the Committee into effect, may be drafted. Carried.

20. Clerical Expense.

It was moved by Henry Rogers, seconded by Louis Packard, that an item of $900 for extra clerical expense in the legal department be included in the budget as item 23 (d).

It was moved by Louis Packard, seconded by C. A. Dukes, that consideration of the budget be postponed until after the receipt of the report of the Special Committee on Dues. Carried.

21. Invitations for Next Annual Session.

The Council fixed the hour of 2 p. m. on Wednesday as the time to hear representatives who wished to present invitations for the next annual session of the California Medical Association.

22. Time of Next Council Meeting.

The Council fixed the hour of 2 p. m. on Monday, May 1, 1939, as the time of the next meeting of the Council.

23. Adjournment.

On motion duly made, seconded and carried, the Council adjourned until 2 p. m. on Monday, May 1, 1939.

Karl L. Schaupp, *Chairman.*
George H. Kress, *Secretary.*

* * *

Minutes of the Two Hundred and Seventy-Fourth (274th) Meeting of the Council of the California Medical Association

The meeting was held in the Directors' Room, Hotel Del Monte, Del Monte, California, Monday, May 1, 1939, at 2 p. m.

1. Call to Order:

The meeting was called to order by Chairman Schaupp, with the following members present: President William W. Roblee, President-Elect C. A. Dukes, Past President Howard Morrow, Speaker Lowell S. Goin, Chairman of Council Karl L. Schaupp; Councilors Calvert Emmons, A. E. Anderson, Louis Packard, A. L. Phillips, O. D. Hamlin, F. N. Scatena, H. A. Rogers, Harry H. Wilson William H. Kiger, Carl R. Howson, T. H. Kelly, C. O. Tanner, P. K. Gilman; Chairman of Public Relations Committee George G. Reinle; Secretary-Editor George H. Kress, General Counsel Hartley F. Peart and his associate, Mr. Howard Hassard.

Absent: Doctor J. B. Harris.

2. Report of Special Committee on Dues and Finances.

Dr. Karl L. Schaupp read the section which was to be presented to the House of Delegates as an addendum to the Council report relating to finances. Doctor Roblee then explained the views of the Committee in arriving at the proposed changes in the budget.

The recommendation of the Committee was that the dues be set at $20 for the year 1940.

It was moved by C. A. Dukes, seconded by G. G. Reinle, that the budget as revised be submitted to the House of Delegates as an addendum to the report of the Council. Carried.

It was moved by George Reinle, seconded by C. A. Dukes, that the annual dues for 1940 be fixed at $20 per member for the calendar year 1940. Carried.

3. Standing Committees.

The report of the Special Committee (Doctors Rogers, Gilman, and Tanner) on Nominations for Membership on Standing Committees was presented, and on motion of F. N. Scatena, seconded by A. E. Anderson, was approved.

The Council's attention was then called to the resignation of John C. Ruddock, Chairman of the Committee on Postgraduate Activities, and Fred B. Clarke, Chairman of the Committee on Health and Public Instruction.

It was moved by Lowell S. Goin, seconded by Alfred L. Phillips, that the resignation of John C. Ruddock, as chairman of the Committee on Postgraduate Activities, be accepted with regret. Carried.

It was moved by Lowell S. Goin, seconded by Alfred Phillips, that the resignation of Fred B. Clarke, be accepted with regret. Carried.

Upon motion duly made and seconded, it was voted to recommend to the House of Delegates, for approval, the Standing Committees, as follows (new members thereon are those whose terms will expire in 1942, to take the places of members whose term expired in 1939. Also, nominations to fill vacancies through resignation):

COMMITTEE ON ASSOCIATED SOCIETIES AND TECHNICAL GROUPS

John V. Barrow (Chairman), Los Angeles	1940
Edwin L. Bruck, San Francisco	1941
Willard H. Newman, San Diego	1942

COMMITTEE ON HEALTH AND PUBLIC INSTRUCTION

Benjamin W. Black, Oakland	1940
Roy Thomas (Chairman), Los Angeles	1941
William Dock, San Francisco	1942

COMMITTEE ON HISTORY AND OBITUARIES

A. Elmer Belt, Los Angeles	1940
Frank R. Makinson (Chairman), Oakland	1941
J. Marion Read, San Francisco	1942

COMMITTEE ON HOSPITALS, DISPENSARIES AND CLINICS

Karl L. Schaupp, San Francisco	1940
George Dawson, Napa	1941
J. Norman O'Neill (Chairman), Los Angeles	1942

COMMITTEE ON INDUSTRIAL PRACTICE

Harry E. Zaiser, Orange	1940
Morton R. Gibbons, San Francisco	1941
Donald Cass (Chairman), Los Angeles	1942

COMMITTEE ON MEDICAL DEFENSE

John P. Nuttall, Santa Monica	1940
George G. Reinle (Chairman), Oakland	1941
William Van Den Berg, Sacramento	1942

COMMITTEE ON MEDICAL ECONOMICS

Edward M. Pallette, Sr., Los Angeles	1940
John H. Graves (Chairman), San Francisco	1941
L. W. Hines, Santa Rosa	1942

COMMITTEE ON MEDICAL EDUCATION AND MEDICAL INSTITUTIONS

John B. Doyle, Los Angeles	1940
B. O. Raulston, Los Angeles	1941
L. R. Chandler (Chairman), San Francisco	1942

COMMITTEE ON MEMBERSHIP AND ORGANIZATION

G. Dan Delprat, San Francisco	1940
George D. Maner (Chairman), Los Angeles	1941
Dewey R. Powell, Stockton	1942

COMMITTEE ON POSTGRADUATE ACTIVITIES

Dwight Wilbur (Chairman), San Francisco	1940
F. E. Clough, San Bernardino	1941
H. E. Henderson, Santa Barbara	1942

COMMITTEE ON PUBLICATIONS

Ralph Eusden (Chairman), Los Angeles	1940
Ruggles A. Cushman, Talmage	1941
Frank E. Toomey, San Diego	1942
Secretary ex officio	
Editor ex officio	

COMMITTEE ON PUBLIC POLICY AND LEGISLATION

E. T. Remmen, Glendale	1940
J. B. Harris (Chairman), Sacramento	1941
T. Henshaw Kelly, San Francisco	1942
President ex officio	
President-Elect ex officio.	

COMMITTEE ON SCIENTIFIC WORK

Lemuel P. Adams, Oakland	1940
J. Homer Woolsey, Woodland	1941
Howard West, Los Angeles	1942
Secretary of Section on General Medicine	
Secretary of Section on General Surgery	
Secretary of California Medical Association (Chairman)	

CANCER COMMISSION

Dr. Charles A. Dukes, as the incoming president, appointed the following members of the Cancer Commission: Clarence Berne to succeed Clarence Toland, who has resigned; Henry J. Ullmann and A. R. Kilgore.

4. Membership.

An application was presented by the San Francisco County Medical Society, requesting that associate membership be granted to Raymond O. Dart, San Francisco, and John B. M. Saunders, San Francisco.

It was moved by William Roblee, seconded by Alfred Phillips, that Raymond O. Dart and J. B. M. Saunders, San Francisco, be granted associate membership in the California Medical Association. Carried.

An application was presented by the San Francisco County Medical Society, requesting the Council to recommend to the House of Delegates of the American Medical Association that Adelaide Brown be granted affiliate membership in the American Medical Association.

It was moved by C. A. Dukes, seconded by Lowell S. Goin, that the Council recommend to the American Medical Association House of Delegates the granting of affiliate membership for Adelaide Brown in the American Medical Association. Carried.

An application was presented by the San Diego County Medical Society, requesting that Edgar Nelson Young be granted retired membership in the California Medical Association.

It was moved by C. O. Tanner, seconded by Henry Rogers, that Edgar Nelson Young, San Diego, be granted retired membership in the California Medical Association. Carried.

5. Consultation with Cultists.

The attention of the Council was called to a resolution of a component county society condemning consultations of members with others than doctors of medicine and providing disciplinary procedure. Doctor Goin again emphasized the necessity of component county societies abiding by the rules laid down in the disciplinary code, and the ineffectuality of resolutions of county societies in matters of suspension and expulsion.

No action taken.

6. Ethics.

The attention of the Council was directed to a matter of ethics of a member of the San Mateo County Society in the treatment of a patient.

It was the sense of the Council that the complaint should be referred to the component county society.

7. Life Members.

The Council considered the recommendation that life membership be granted at the age of sixty upon payment of a specific sum. The change in financial set-up of the Association that such action would entail was discussed, and the necessity of a comprehensive study of the proposed action, before taking action, was emphasized.

It was moved by C. A. Dukes, seconded by Howard Morrow, that the Council recommend to the House of Delegates that a committee be appointed to study the proposal whereby, under certain conditions, on and after the age of sixty, it might be possible for members to purchase life membership in the California Medical Association. Motion carried.

8. Woman's Auxiliary.

After discussion of the request of the Woman's Auxiliary that a supplement containing a roster of the Woman's Auxiliary be published, it was moved by Henry Rogers, seconded by George Reinle, that the 1940 roster of members of the California Medidal Association contain a section devoted to a roster of members of the Woman's Auxiliary. Carried.

9. Report of Legal Counsel.

(a) *Tator vs. Pacific Employers Insurance Company.*—The General Counsel reported that a favorable decision had been rendered by the Supreme Court of the United States in this case, and that further report would be included in his report to the House of Delegates.

(b) *Commercial Insurance Companies.*—The request of a commercial insurance company for approval as a malpractice insurance carrier was referred to the Committee on Medical Defense.

(c) *Standard Vaccines, Inc.*—General Counsel Peart reported that he had submitted to the San Bernardino County Medical Society, at its request, an opinion on Standard Vaccines, Incorporated, and that a copy of the letter had been placed in the files of the Association.

(d) *Engleking vs. Carlson.*—General Counsel Peart stated that the status of the case of *Engleking* vs. *Carlson* was included in his report for submission to the House of Delegates.

(e) *Jordt vs. State Board of Education.*—General Counsel Peart reported that a decision had been rendered by the Superior Court in Sacramento County. He further reported that the Superior Court had decided that an osteopathic physician and surgeon is eligible to qualify for a health and development certificate.

(f) *Social Security Taxes: Retroactive Ruling of Commissioner of Internal Revenue.*—The General Counsel reported that Social Security taxes, covering the year 1937 and the first six months of 1938, had been paid by the Association under protest. He further reported that the protest was based upon the fact that, during 1937 and 1938, a ruling of the Collector of Internal Revenue, First District of California, was in effect under the terms of which the Association was exempt from Social Security taxes. He also reported that the Commissioner of Internal Revenue has reversed the exemption ruling of the Collector of Internal Revenue, and has held that the Association is liable for Social Security taxes during the period that the Collector's ruling was in effect. The General Counsel reported that he believed the ruling of the Commissioner to be erroneous and that he recommended the filing of a refund claim, with respect to Social Security taxes for the period in question.

On motion duly made, seconded and unanimously carried, the Secretary was authorized and instructed to execute and cause to be verified and filed a claim for refund, prepared by Legal Counsel, covering Social Security taxes paid for the year 1937, and the first six months of the year 1938.

10. Appeal.

Association Secretary Kress reported that Dr. A. L. Bramkamp of Riverside would act as referee in the hearing of Dr. A. T. Martin before the Los Angeles County Medical Association.

11. Speakers' Committee.

The Secretary reported that Chairman of Public Relations Committee Reinle had appointed committees in the northern and southern parts of the state to speak before societies and other organizations on medical and hospital service and health problems. Doctor Kress stated the northern speakers were working under the chairmanship of Dr. John Cline, and the southern committeemen under Dr. Paul A. Quaintance.

It was moved by C. A. Dukes, seconded by Lowell S. Goin, that the action of the Chairman of the Committee on Public Relations in the appointment of a Speakers' Bureau, be approved. Carried.

It was stated that, when necessary, incidental travel expense could be budgeted from the allocation of the Department of Public Relations.

12. National Research Council.

Invitation from the National Research Council to participate in the Pacific Science Congress, was presented. No official action was considered necessary.

13. Public Health Defense League.

The attention of the Council was directed to an organization known as the "Public Health Defense League." This is a separate and distinct organization, and should not be confused with the Public Health League of California.

14. Well-Baby Clinics.

Correspondence regarding the improper procedures by representatives of the Bureau of Child Welfare of the State Board of Public Health, with particular relationship to the private practice of medicine, was discussed. Doctor Morrow stated that the State Board of Health had investigated the complaint and the matter had been taken care of to the satisfaction of those concerned. Doctor Packard suggested that the manner of operation in Kern County should also be called to the attention of the State Health Department workers. Doctor Morrow stated that any complaints submitted in writing would be given immediate consideration and an attempt made to clarify difficulties.

15. Health and Hospital Service Plans.

The request for approval of a lay manager of a health and hospitalization plan in Santa Clara was considered.

The Council felt that organizations offering medical and hospital service and operating on a profit basis were inimical to the development of the nonprofit plan of California Physicians' Service, and that approval of such commercial and profit-seeking plans was undesirable.

16. Medical Library Association.

It was moved by T. Henshaw Kelly, seconded by Lowell Goin, that the request of the National Medical Library Association concerning a proposed publication be filed. Carried.

17. House of Delegates.

It was moved by Carl Howson, seconded by George Reinle, that a committee, consisting of the Chairman of the Council. the Speaker of the House, the President, and the Secretary-Treasurer, consult with the sections on General Medicine and General Surgery and endeavor to make arrangements for use of one of the large auditoriums in time to start the second meeting of the House of Delegates at 4 p. m. Wednesday. Carried.

It was moved by Harry Wilson, seconded by O. D. Hamlin, that a Committee of Four, consisting of the President of the Association, the Chairman of the Council, the Speaker of the House of Delegates, and the Chairman of the Program Committee, who is the Secretary-Treasurer, work out arrangements and make recommendations to permit more time for the business of the second meeting of the House of Delegates. Carried.

18. Time of Next Council Meeting.

Because the docket of business had been covered, the Chairman stated that the next meeting of the Council would be held at 2 p. m. on Wednesday, instead of on Tuesday.

19. Adjournment.

There being no further business, the meeting adjourned.

Karl L. Schaupp, *Chairman.*
George H. Kress, *Secretary.*

Minutes of the Two Hundred and Seventy-Fifth (275th) Meeting of the Council of the California Medical Association

The meeting was held in the Directors' Room, Hotel Del Monte, Del Monte, California, Wednesday, May 3, 1939, at 2 p. m.

1. Call to Order:

The meeting was called to order by Chairman Schaupp, with the following members present: President William W. Roblee, President-Elect C. A. Dukes, Past President Howard Morrow, Speaker Lowell Goin, Chairman of Council Karl L. Schaupp; Councilors Calvert Emmons, A. E. Anderson, Louis Packard, A. L. Phillips, O. D. Hamlin, F. N. Scatena, H. A. Rogers, T. Henshaw Kelly, J. B. Harris, Harry H. Wilson, William H. Kiger, C. O. Tanner, P. K. Gilman, Carl Howson; Chairman of Public Relations Committee George G. Reinle, Secretary-Editor George H. Kress, General Counsel Hartley F. Peart and his associate, Mr. Howard Hassard.

2. Invitations for Next Annual Session.

The Chairman stated that the first order of business would be the presentation of invitations for the next annual session of the Association.

Representatives from Long Beach, Riverside, Del Monte, and Coronado addressed the Council, indicating the convention facilities offered by their respective communities.

The Secretary stated written invitations had also been received from San Francisco, Los Angeles, and Santa Barbara.

It was moved by William Kiger, seconded by Louis Packard, that the next annual session of the California Medical Association be held at Hotel del Coronado, Coronado, San Diego. Carried.

3. Health Insurance Legislation.

A letter was presented from the Orange County Medical Association voicing the opposition of that unit to any form of compulsory health insurance, and recommending that the plan of the California Physicians' Service be given ample time for trial before any other type of medical service is placed in operation. Carried.

4. Nurses Legislation.

It was reported that the proposed Nurses' Bill was passed out of Committee with the recommendation that it "do pass." The importance of incorporating a minimum standard for training schools was discussed.

5. State Board of Health.

In the absence of General Counsel Peart, who was attending a meeting of the Trustees of California Physicians' Service, his associate, Mr. Hassard, discussed the proposed legislation to abolish the State Board of Public Health, stating that the California constitution provides for the existence and maintenance of a State Board of Public Health, so that it cannot be abolished by legislative enactment.

6. Trichinosis.

The letter from the Alameda County Medical Association, regarding an "Act to Prevent Trichinosis," was referred to the Committee on Public Policy and Legislation.

7. Premarital and Prenatal Tests for Syphilis.

The request of the California units of the American Society for Social Hygiene for endorsement of the proposed premarital and prenatal tests for syphilis was presented. Doctor Morrow stated that the venereal disease campaign was being carried on by the State Department of Public Health, and that that body had recommended that the bills "do pass."

It was moved by A. E. Anderson, seconded by Louis Packard that the California Medical Association endorse the prenatal and premarital examination for syphilis. Carried.

8. Wagner Bill.

The present status of the Wagner Bill, now before the Federal Congress, was discussed and it was reported that indications were that the bill would not go on to passage at this time.

9. Association of California Hospitals.

The request of the Hospital Association, to be represented at the meetings at which legislation was discussed, was referred to the Committee on Public Policy and Legislation, as occasion may arise.

10. Narcotic Legislation.

After consideration of the request of the Division of Narcotic Enforcement, it was moved by Howard Morrow seconded by O. D. Hamlin, that the California Medical Association endorse the proposed narcotic legislation. Carried.

11. Optometry Bill.

It was moved by Louis Packard, seconded by F. N. Scatena, that the Council approve the action of the Legislative Committee in working for the passage of Assembly Bill 516. Carried.

12. Dangerous Fireworks.

It was moved by Howard Morrow, seconded by F. N. Scatena, that the Council endorse Senate Bill No. 6 for the control of dangerous fireworks, as sponsored by the United States Junior Chamber of Commerce. Carried.

13. Letter of Protest.

Letter from the Medical-Dental Democratic Club, protesting an article in the Los Angeles County Medical Association Bulletin, was presented. The letter was ordered filed.

14. Palo Alto Hospitalization Insurance Association.

Correspondence relative to the Palo Alto Hospitalization Group, Pacific Employers Insurance Company, and related matters were presented.

Doctor Reinle, chairman of the committee appointed to review medical and hospital service policies of commercial insurance companies, reported that the correspondence from the Palo Alto Hospitalization Group had been referred to his committee, and that the Committee desired the Council's suggestions in the matter. It was the sense of the Council that no positive action should be taken by the Committee or the Council unless requests were received directly from insurance companies involved.

15. Time of Next Council Meeting.

The time of the annual organization meeting of the Council was fixed for 9 a. m. Thursday.

Karl L. Schaupp, *Chairman.*
George H. Kress, *Secretary.*

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Minutes of the Two Hundred and Seventy-Sixth (276th) Meeting of the Council of the California Medical Association

The meeting was held in the Directors' Room, Hotel Del Monte, Del Monte, California, Thursday, May 4, 1939, at 9 a. m.

1. Call to Order.

The meeting was called to order by President Dukes, who introduced the new members of the Council: Councilor for Second District, George D. Maner of Los Angeles; Councilor for the Fifth District, D. Kelly Canelo of San Jose; Councilors-at-large, Elbridge J. Best of San Francisco. Frank MacDonald of Sacramento, newly elected Councilor for the Eighth District, was unavoidably absent.

The following members were present: President Charles A. Dukes, President-Elect Harry H. Wilson, Past President William W. Roblee, Speaker Lowell Goin; Councilors Karl L. Schaupp, Calvert L. Emmons, A. E. Anderson, Louis Packard, C. Kelly Canelo, O. D. Hamlin, F. N. Scatena, H. A. Rogers, William H. Kiger, C. O. Tanner, P. K. Gilman, Elbridge Best, George Maner; Chairman of Public Relations Committee George G. Reinle, Secretary-Editor George H. Kress. Mr. Peart and Mr. Hassard arrived following the executive session. Dr. J. B. Harris was present during the discussion of certain legislative matters.

2. Chairman of Committee on Public Relations.

President Dukes stated that, on account of the inability to secure a quorum for a meeting of the Committee on Public Relations, George G. Reinle would hold office as Chairman of the Committee as provided in the Constitution until an election took place.

3. Election of Chairman of Council.

Doctor Dukes stated that the first order of business would be the election of a chairman of the Council.

William Roblee nominated Karl Schaupp as Chairman of the Council for the ensuing year; such nomination was seconded by Louis Packard. There being no other nominations, the President declared the nominations closed, and it was voted that the Secretary cast the unanimous ballot of the Council for Doctor Schaupp. Doctor Schaupp then took the chair.

4. Election of Vice-Chairman of Council.

William H. Kiger nominated Charles A. Dukes as Vice-Chairman of the Council for the ensuing year. The nomination was seconded by F. N. Scatena. There being no further nominations, the Chairman declared the nominations closed, and it was voted that the Secretary cast the unanimous ballot of the Council for Dr. Charles A. Dukes as Vice-Chairman.

5. Executive Session.

Upon motion duly made and seconded, the Council went into executive session.

Chairman Schaupp appointed George G. Reinle to act as secretary for the executive session.

Chairman Schaupp brought up the matter of the proposed survey of the Central Office, as indicated in the resolutions submitted to the House of Delegates.

Discussion was then had of the election of a secretary and the term of office thereof. The election of a secretary was discussed by Doctors Roblee, Dukes, Anderson, Kiger, and Wilson.

It was moved by Doctor Dukes, and seconded by Doctor Anderson, that Doctor Kress be retained as Secretary-Treasurer and Director of Public Relations and Editor until the 1940 annual session, at his present salary. Carried.

It was moved by Dr. Lowell S. Goin, and seconded by Dr. Louis Packard, that the Council rise from executive session. Carried.

6. Appointment of Legal Counsel.

On motion duly made, seconded and carried, Mr. Hartley F. Peart was appointed General Counsel of the Association for the ensuing year at the same retainer.

On motion duly made, seconded and carried, Hr. Hubert Morrow was appointed associate general counsel for the ensuing year, without retainer.

7. Clerical Expense.

It was moved by Charles Dukes, seconded by P. K. Gilman, that the item of extra clerical expense for the legal department, as included in the budget, be approved. Carried.

8. Councilor Vacancy.

It was pointed out that the election of Harry Wilson as president-elect caused a vacancy as councilor-at-large.

William H. Kiger nominated William Daniels of Los Angeles as councilor-at-large to fill the vacancy of Dr. Harry Wilson; such nomination was seconded by F. N. Scatena.

Calvert Emmons nominated Earl Moody of Los Angeles as councilor-at-large to fill the vacancy of Dr. Harry Wilson; such nomination was seconded by George Maner.

A vote was taken on the nominations: Doctor Moody having received the majority of the votes cast, the Chairman declared him elected councilor-at-large to fill the unexpired term of Harry Wilson; term expiring in 1941.

9. Committee on Public Policy and Legislation.

Dr. Junius B. Harris of Sacramento stated that it was necessary to formulate a plan for the handling of legislative matters in the future, and outlined the ideas he had in mind. A tentative plan would be to have two men from each assembly district and one from each senatorial district, these to serve as a local legislative committee. In addition, perhaps, an employed full-time coördinator, who would be on service both during and between the biennial legislative sessions. Doctor Harris was of the opinion that the good will that the profession engenders in the community rests largely upon the extent to which physicians practice good medicine and maintain kindly contacts with patients and fellow citizens, so that these may then be counted upon for support of legitimate public health standards. Doctor Harris stated that the plan he had in mind was not to be confused with the proposed set-up, as outlined in the House of Delegates resolutions, concerning publicity and allied endeavors.

In the general discussion that followed, the sentiment that the services of Doctor Harris, as a member of the Legislative Committee, should be retained met with unanimous approval.

Action taken: It was moved by Lowell S. Goin, seconded by P. K. Gilman, that the Chairman of the Council appoint a Committee of Three to study the subject that had been discussed, with instructions to submit a plan of a proposed organization, with recommendations, and report thereon at the next meeting of the Council.

The Chairman appointed as members of the committee: the President of the Association, Doctor Dukes; the Speaker of the House, Doctor Goin; and Dr. J. B. Harris, the Chairman of the Committee on Public Policy and Legislation.

10. Principles of Ethics.

The Council instructed Dr. Elbridge Best, as a member of the House of Delegates of the American Medical Association, to act as a special committee to carry out the instructions contained in Resolution No. 7 of the California Medical Association House of Delegates relating to a recodification of the Principles of Ethics.

It was emphasized that the resolution did not contemplate a change in the basic ethics of the profession which remain unchangeable, but that it was advocated therein that the Code of Ethics be formulated in line with canons of law; and where indicated, the phraseology be clarified, with supplementary notes on past decisions of the American Medical Association Judicial Council that might be of the nature of precedent, and therefore of value in current and future procedures.

It was the sense of the Council, if the American Medical Association committee reported favorably thereon, it would then be in order that similar action be taken in California for guidance of the State Association and its component county societies.

At the request of the Council the Chairman appointed a Committee of Three, consisting of Doctors Best, Goin, and Dukes to draft a code for possible use in California.

11. Special Assessment of $10: Due and Payable June 1, 1939.

The assessment of $10 per member levied in accordance with Substitute Resolution No. 6 (combining Resolutions Nos. 6, 8, 12, 13) was discussed.

It was moved by William W. Roblee, seconded by Louis A. Packard, that an assessment of $10 per member be levied upon all active members of this Association, California Medical Association, in accordance with the instructions of the House of Delegates as embodied in amended resolution No. 6, adopted by the House on May 3, 1939, and that notice of this special assessment be given in writing to each active member of the Association by the Secretary as soon as possible. As provided in the resolution of the House of Delegates, the said assessment is due and payable June 1, 1939, and, if not paid within sixty days thereafter, loss of membership shall occur. Motion carried.

It was pointed out that, in accordance with provisions in the California Medical Association Constitution and By-Laws, this assessment must be paid through the component county societies, in the same manner as the annual dues, that is, checks to be drawn by members in favor of respective component county societies, and county societies to then forward reports and checks to cover to the Central Office of the Association.

It was agreed that Doctor Alson Kilgore and General Counsel Peart should prepare a letter of explanation for the Council to accompany the notice of assessment.†

12. Auditing Committee.

The Chairman of the Council appointed as the Auditing Committee for the ensuing year, P. K. Gilman (Chairman), O. D. Hamlin, and Elbridge Best. The appointments were approved by the Council.

13. Date of Next Council Meeting.

It was moved by Lowell S. Goin, seconded by A. E. Anderson, that the next meeting of the Council be held at San Francisco on Saturday, June 3, 1939. Motion carried. Meeting to convene at 9 o'clock in the Sir Francis Drake Hotel, San Francisco.

14. Adjournment.

There being no further business, the Council adjourned.

Karl L. Schaupp, *Chairman.*
George H. Kress, *Secretary.*

A. M. A. ANNUAL SESSION—ST. LOUIS*

San Francisco, California,
May 22, 1939.

At the 1939 session of the American Medical Association House of Delegates there were present from California its full delegation, consisting of Drs. William R. Molony, Sr., Robert A. Peers, George G. Reinle, Edward M. Pallette, J. P. Nuttall, Lyell C. Kinney, and Elbridge J. Best. This was a complete delegation from California.

California was favored with three delegates on Reference Committees: Dr. William R. Molony, Sr., on Reference Committee on Sections and Section Work; Dr. Edward M. Pallette, Reference Committee for Hygiene and Public Health; and Dr. Elbridge Best on Reference Committee on Reports of Officers.

At this session Dr. Nathan B. Van Etten of New York received the honor of president-elect; Dr. Alphonse McMann of St. Louis, vice-president. Dr. Ray Lyman Wilbur was reëlected to the Council on Medical Education and Hospitals. Dr. E. L. Henderson was elected as the new member of the Board of Trustees. Atlantic City was chosen for the 1942 meeting. (Editor's Note: The American Medical Association meets in New York in 1940, and in Cleveland in 1941.)

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† For Official Notice, see page 426.

* Report submitted by Elbridge J. Best, M. D., San Francisco.

The California delegation presented the resolution on rearranging the Principles of Ethics. There was considerable objection from the Chairman of the Judicial Council, and the final outcome was that the Chairman of the Reference Committee on the amendments to the constitution and by-laws, after speaking on the question of "changes" of our ethics, moved that this resolution be referred to the Judicial Council. Resolution follows:

Resolution Concerning the Principles of Ethics*

WHEREAS, In these and other troublous times, in order to maintain the high quality and ideals of our medical profession, it is most essential to uphold the standards of the Principles of Medical Ethics without compromise; and

WHEREAS, Since the Principles of Medical Ethics were rewritten in 1912, there have arisen many problems not known to the leaders of our profession twenty-seven years ago; and

WHEREAS, Because of the nationwide influence of members of component societies appearing on public platforms, in the press, over the radio, etc., and because of the arrangement and wording of the Principles of Medical Ethics, component county medical societies have recently found it next to impossible to draw up sound charges to discipline members who have violated our Medical Ethics; therefore be it

Resolved, That the Speaker of this House of Delegates appoint a Committee of five Fellows of the American Medical Association to study the Principles of Medical Ethics and the form of the code of ethics of the legal profession, having in mind the rearrangement of our principles of ethics for continuity, rewording for clarity, adding a commentary following each principle to illustrate the intent, and to quote relating decisions of the Judicial Council; and be it further

Resolved, This Committee be directed to report its recommendations to the 1940 Session of the American Medical Association House of Delegates.

A resolution on the patenting of medicine and instruments caused some discussion, and the Judicial Council was asked to study the question of amending Article 1, Section 5, of the Principles of Ethics.

The question of special representation in the American Medical Association House of Delegates for women physicians and problems relating to negro physicians were introduced. These resolutions, after producing considerable discussion, were left in *status quo,* but with clarified wording.

The by-laws were amended to put nine members on the Council on Medical Education and Hospitals, each to serve a nine-year term and ineligible for reëlection.

Doctor Braash reported on the American Medical Association Survey on Medical Care. His report was on the results up to date, which are incomplete, but reveal vacant hospital beds in private institutions; and that the figure 40,000 for those needing medical care is more nearly the truth than the figure 40,000,000 reported by certain political bodies.

The Board of Trustees, the Iowa delegation and the Texas delegation submitted a resolution regarding the Wagner Act. The committee appointed in the September, 1938, special meeting, for similar study, was reappointed to report on the Wagner Act. After three days and nights of work with medical and lay opinions, a report was rendered the House of Delegates in executive session containing a summary of twenty-two items, showing American Medicine's opinion in no uncertain terms, and bringing out the lack of safeguards to private practice and revealing this Act as contrary to the best interests of the American people.

REPORT OF REFERENCE COMMITTEE ON THE WAGNER HEALTH BILL*

Summary

1. The Wagner Health Bill does not recognize either the spirit or the text of the resolutions adopted by the House of Delegates of the American Medical Association in September, 1938.
2. The House of Delegates cannot approve the methods by which the objectives of the National Health Program are to be obtained.
3. The Wagner Health Bill does not safeguard in any way the continued existence of the private practitioners who have always brought to the people the benefits of scientific research and treatment.
4. The Wagner Health Bill does not provide for the use of the thousands of vacant beds now available in hundreds of church and community general hospitals.
5. This Bill proposes to make federal aid for medical care the rule rather than the exception.
6. The Wagner Health Bill does not recognize the need for suitable food, sanitary housing and the improvement of other environmental conditions necessary to the continuous prevention of disease.
7. The Wagner Health Bill insidiously promotes the development of a complete system of tax supported governmental medical care.
8. While the Wagner Health Bill provides compensation for loss of wages during illness, it also proposes to provide complete medical service in addition to such compensation.
9. The Wagner Health Bill provides for supreme federal control: federal agents are given authority to disapprove plans proposed by the individual states.
10. The Wagner Health Bill prescribes no method for determining the nature and extent of the needs for preventive and other medical services for which it proposes allotments of funds.
11. The Wagner Health Bill is inconsistent with the fundamental principles of medical care established by scientific medical experience and is therefore contrary to the best interests of the American people.
12. The fortunate health conditions which prevail in the United States cannot be disassociated from the prevailing standards and methods of medical practice.
13. No other profession and no other group have done more for the improvement of public health, the prevention of disease and the care of the sick than have the medical profession and the American Medical Association.
14. The American Medical Association would fail in its public trust if it neglected to express itself unmistakably and emphatically regarding any threat to the national health and well-being. It must, therefore, speaking with professional competence, oppose the Wagner Health Bill.
15. The House of Delegates would urge the development of a mechanism for meeting the needs for expansion of preventive medical services, extension of medical care for the indigent and the medically indigent, with local determination of needs and local control of administration, within the philosophy of the American form of government and without damage to the quality of medical service.
16. The fundamental question is how and when a state should be given financial aid by the Federal Government out of the resources of the states as a whole, pooled in the Federal Treasury.
17. The bizarre thinking which evolved the system of federal subsidies—sometimes called "grants-in-aid"—is used to induce states to carry on activities suggested frequently in the first instance by officers and employees of the Federal Government.
18. The use of federal subsidies to accomplish such federally determined activities has invariably involved federal control.
19. Any state in actual need for the prevention of disease, the promotion of health and the care of the sick should be able to obtain such aid in a medical emergency without stimulating every other state to seek and to accept similar aid, and thus to have imposed on it the burden of federal control.
20. The mechanism by which this end is to be accomplished, whether through a federal agency to which any state in need of federal financial assistance can apply, or through a new agency created for this purpose or through responsible officers of existing federal agencies, must be developed by the Executive and the Congress, who are charged with these duties.
21. Such a method would afford to every state an agency to which it might apply for federal assistance without involving every other state in the Union or the entire government in the transaction.
22. Such a method would not disturb permanently the American concept of democratic government.

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* Presented by the California Delegation, as instructed by the House of Delegates of the California Medical Association.

* Submitted to the American Medical Association House of Delegates on May 17, 1939, at St. Louis, Missouri.

Refers to "Wagner Health Bill," S. 1620, Seventy-Sixth United States Congress, 1939.

C. M. A. DEPARTMENT OF PUBLIC RELATIONS[†]

HOW ASSEMBLYMEN VOTED ON THE PROPOSED COMPULSORY HEALTH LAW (ASSEMBLY BILL 2172)

On Tuesday afternoon, May 16, the proposed compulsory health insurance law was given place on the Assembly calendar, as a special order. In the Assembly chamber on that afternoon, the tenseness of the situation was quite evident, for there was to be witnessed a test vote on one of the Administration's "must" measures. Elsewhere in this issue other items in relation thereto are given.[*]

For the information of members, the roll call vote is printed below. The test vote was on a certain amendment, the "Aye" votes being cast by Assemblymen who, presumably, are in favor of the compulsory health measure known as Assembly Bill 2172, the "No" votes indicating the Assemblymen who are opposed to a compulsory health insurance law.

Component county societies and members of the California Medical Association who are interested in the proposed legislation may wish to carefully look over the lists.

Vote as recorded follows:

"Aye" Votes (Assemblymen Supposedly in Favor of a Compulsory System)

Name	*Occupation*	*Party*	*Dist.*	*Home Address*
Atkinson, Maurice E.	Journalist	D	70	906 Obispo Ave., Long Beach
Bennett, F. Ray	Attorney	D	51	5041 Gafford St., Los Angeles
Burns, Michael J.	Master Mechanic	R	1	1644 Summer St., Eureka
Cassidy, James M.	Manufacturer's Representative	D	13	1520 Eighty-ninth Ave., Oakland
Collins, George D., Jr.	Attorney	D	22	1456 Union St., San Francisco
Del Mutolo, M. G.	Attorney	D	31	1731 Glen Una Way, San Jose
Desmond, Earl D.	Attorney-Farmer	D	9	2022 Twenty-second St., Sacramento
Dills, Ralph C.	Teacher	D	69	1505 N. Spring St., Compton
Doyle, Thomas J.	Business Manager-Retired Ry. Conductor	D	45	4333 Griffin Ave., Los Angeles
Gallagher, Dan	Drayman	D	23	1670 Folsom St., San Francisco
Gannon, Chester F.	Attorney	D	8	3543 H St., Sacramento
Gilmore, Joseph P.	Secretary	D	21	442 Excelsior Ave., San Francisco
Hawkins, Augustus F.	Business	D	62	719 E. 43d Place, Los Angeles
Heisinger, S. L.	Farmer-Poultryman	D	37	Rt. 4, Box 90E, Fresno
Kilpatrick, Vernon	Publisher	D	55	1116 S. Flower St., Los Angeles
King, Cecil R.	Merchant	D	67	1152 W. 88th St., Los Angeles
Lore, Elmer E.	Printer	D	42	6304 Rodford, North Hollywood
Maloney, Thomas A.	Insurance	R	20	350 Missouri St., San Francisco
Massion, Jack	Druggist	D	66	846 E. 77th St., Los Angeles
Meehan, Henry P.	Insurance Broker	D	17	4143 Grove St., Oakland
Miller, Eleanor	Teacher	R	47	251 S. Oakland Ave., Pasadena
Miller, George P.	Civil Engineer	D	14	1424 Benton St., Alameda
Peek, Paul	Attorney	D	71	2363 Pine Ave., Long Beach
Pelletier, John B.	Research	D	44	248 S. Olive St., Los Angeles
Reaves, Fred	Engineer	D	68	964 Tenth St., San Pedro
Richie, Paul A.		D	79	4264 Menlo Ave., San Diego
Rosenthal, Ben	Attorney	D	52	1924 E. 4th St., Los Angeles
Salsman, Byrl R.	Attorney	R	30	1861 Fulton St., Palo Alto
Tenney, Jack B.	Attorney	D	46	724 E. Fairview Blvd., Inglewood
Turner, Rodney L.	Farmer	D	41	1117 Jefferson St., Delano
Voigt, Ernest O.	Real Estate	D	61	3651 Cardiff Ave., Los Angeles
Weber, Charles M.	Civil Engineer-Farmer	R	11	300 First National Bldg., Stockton
Williamson, Ray	Attorney	R	26	41 Roselyn Terrace, San Francisco
Yorty, Samuel William	Manufacturing	D	64	463 S. Lake St., Los Angeles

"No" Votes (Assemblymen Supposedly Not in Favor of a Compulsory System)

Name	*Occupation*	*Party*	*Dist.*	*Home Address*
Allen, Don A.	Engineer	D	63	1226 W. 30th St., Los Angeles
Bashore, Lee T.	Rancher	R	49	250 Live Oak, Glendora
Burns, Hugh M.	Funeral Director	D	36	2055 San Joaquin St., Fresno
Burson, Roscoe W.	Farmer	R	40	Fillmore
Carlson, Arthur W.	Attorney	R	16	Piedmont
Clarke, George A.	Farmer	R	33	Rt. 1, Box 54, Le Grand
Corwin, Gordon W.	Citrus Grower	R	73	749 Chestnut Ave., Redlands
Cronin, Melvyn I.	Attorney	R	25	1424 Fifth Ave., San Francisco
Crowley, Ernest C.	Attorney	D-R	5	Suisun
Daley, Jeanette E.	Contractor	D	78	4430 Boundary St., San Diego
Dilworth, Nelson S.	Farmer	R	76	119 N. Buena Vista St., Hemet
Donnelly, Hugh P.	Insurance	D	32	114 Lyons Ave., Turlock
Evans, John W.	Accountant	D	65	717½ W. 46th St., Los Angeles
Field, C. Don	Trucking Contractor	R	43	1552 Rideway Dr., Glendale
Fulcher, Clinton J.	Garage	D	2	Lookout
Garland, Gordon H.	Citrus Grower-Farmer	D	38	Woodlake
Green, Robert Miller	Attorney	R	28	214 Nineteenth Ave., San Francisco
Houser, Frederick F.	Attorney	R	53	19 W. Pine St., Alhambra
Johnson, Gardiner	Attorney	R	19	765 San Luis Rd., Berkeley
Kellems, Jesse Randolph	Minister	R	60	454 Cuesta Way, Bel-Air, Los Angeles
Kepple, Gerald C.	Attorney	R	50	1952 Valley View, Whittier
Knight, T. Fenton	Rancher	R	48	Rt. 1, Box 390, La Canada
Kuchel, Thomas H.	Attorney	R	75	Bank of America Bldg., Anaheim
Leonard, Jacob M.	Commercial Secretary	R	34	Hollister
Lyon, Charles W.	Attorney	R	59	1052 S. Redondo Blvd., Los Angeles
Miller, Eleanor	Teacher	R	47	251 S. Oakland Ave., Pasadena
Millington, Seth	Lawyer	D	4	Gridley
O'Donnell, John H.	Attorney	D	3	608 Cleveland St., Woodland
Phillips, James H.	Attorney	R	18	27 Contra Costa Pl., Oakland

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[†] The complete roster of the Committee on Public Relations is printed on page 2 of the front advertising section of each issue. Dr. George G. Reinle of Oakland is the chairman, and Dr. George H. Kress is the secretary. Component county societies and California Medical Association members are invited to present their problems to the committee. All communications should be sent to the director of the department, Dr. George H. Kress, Room 2004,

[*] See page 455.

Name	*Occupation*	*Party*	*Dist.*	*Home Address*
Poulson, Norris	Certified Public Accountant	R	56	3729 Tracy St., Los Angeles
Redwine, Kent H.	Attorney	R	57	1618 N. Las Palmas Ave., Los Angeles
Scudder, Hubert B.	Insurance-Real Estate	R	7	506 S. Main St., Sebastopol
Sheridan, Bernard A.	Attorney	R	15	2314 Mitchell St., Oakland
Stream, Charles W.	Real Estate-Insurance	R	80	P. O. Box 21, Palm City
Thorp, James E.	Farmer	R	12	Lockeford
Thurman, Allen G.	Newspaperman	R	6	Colfax
Walker, Clarence R.	Farmer	R	77	Westmorland
Waters, Frank J., Jr.	Lawyer	R	58	1163 Fourth Ave., Los Angeles
Watson, Clyde A.	Orange Grower	D	74	273 N. Harwood St., Orange
Weybret, Fred	Retired	R	35	Star Route, Soledad
Wollenberg, Albert C.	Attorney	R	27	2748 Steiner St., San Francisco

Not Voting—Andreas, Call, O'Day, Robertson, Sawallisch.

PRIZES FOR SCIENTIFIC EXHIBITS

The California Medical Association Committee on Scientific Program this year awarded three diplomas of merit as prizes for outstanding presentations in the scientific exhibit division.

The prize winners were selected by three members of the Association, each unknown to the other, who gave ratings on the five exhibits which in their respective opinions were best.

The sealed reports submitted by the three judges were then canvassed and the final decision made. The three judges were Doctors John Sampson, San Francisco; Herbert Johnstone, Anaheim, and Orris Myers, Eureka.

First prize went to the exhibit on "Gastroscopic Studies," presented by Allan L. Cohn, Rubin Gold, Alfred White, all of San Francisco. Much of the work in this exhibit was done at Mount Zion Hospital.

The second prize, that of first honorary mention, was awarded to the exhibit on "Gastro-Enterostomy and Jejunoplasty Transparencies" by Carl L. Hoag, John B. DeC. M. Saunders, Harold H. Lindner, and John M. Moore, all of San Francisco.

The third prize, that of second honorary mention, went to the exhibit on "Reconstructive Plastic and Oral Surgery," presented by Arthur E. Smith and James B. Johnson, both of Los Angeles.

The diploma certificates, ornamented with the seal of the Association and suitably engrossed and framed, have been presented to the three prize winners.

CALIFORNIA PHYSICIANS' SERVICE*

Informative Bulletins

Bulletin I

California's statewide voluntary prepayment plan for medical, surgical and hospital care is ready for launching at rates of $2.50 a month, or less, to employed groups of five or more people, or to other groups organized originally for purposes other than those of medical care.

Trustees of California Physicians' Service, which includes in its professional membership a great majority of the licensed doctors of medicine in active general practice in the state, included in this announcement the following provisions of the plan:

Complete medical, surgical and hospital care for all illness or accidents, with a few specific exemptions such as mental cases, drug or alcoholic addiction, preëxisting ailments or results of lawless acts, at $2.50 a month, prepaid.

The same care will be offered with the patient paying the cost of the first two doctor's visits in any one illness or accident, at $2 a month.

The Service at the start will be offered only to groups of employed or other persons, but the group can be as limited in number as five persons, provided satisfactory guarantees of financial stability are given. Groups must collect monthly prepayments from their members and remit as a group to California Physicians' Service, or employers can make deductions for the employees' groups and remit for the groups.

Answering numerous inquiries, the Service trustees state that the rates within a group can be regulated by the group itself, so long as the rate of $2.50 or $2 a month, as the case may be, is maintained in the group payment to California Physicians' Service. With the service based on an average group income not to exceed $3,000 a year, this would permit higher-paid employees to pay more than $2.50 a month in order to permit the office boy or janitor to join at a lower monthly prepayment.

Families of group members, and later individuals, will be admitted to beneficiary membership when the many groups now seeking membership are assimilated and sufficient experience through actual operation of the plan has been gained, the trustees stated.

COUNTY SOCIETIES

SACRAMENTO COUNTY

The regular meeting of the Sacramento Society for Medical Improvement was called to order by President Manuel Azevedo in the Auditorium at Twenty-Ninth and L streets on April 18. There were fifty-two members and guests present.

Dr. Paul Gliebe of San Francisco presented the paper of the evening, his subject being *Emotions in Physical Disease*. Doctor Gliebe especially stressed the recent work being done on the anxiety states, fatigue neurosis and psychoses, and their treatment with sodium chlorid. In many of the depressed states they have found the absence of free hydrochloric acid in the stomach, associated with low blood chlorids and an alkaline urine, due to hyperventilation or overingestion of alkalies. The paper was very well presented and elicited much discussion.

Drs. A. A. Atkinson, Eric Blunden, Pearson Kellogg, and L. Specker were unanimously elected to membership in the Society.

Under new business it was moved, seconded, and so passed, that the name of Dr. Frank MacDonald be presented at the Del Monte annual session to fill the vacancy created by the resignation of Dr. J. B. Harris as councilor-at-large.

Dr. Norris Jones reported for the Public Relations Committee. G. E. Millar, *Secretary.*

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SAN BERNARDINO COUNTY

The meeting of the San Bernardino County Medical Society was held in the San Bernardino County Charity Hospital on Tuesday, May 9.

The meeting was opened by the president, Dr. Delbert B. Williams, at 8 p. m. About sixty members and guests were present.

The Secretary gave a few highlights of the proposed fee schedule for California Physicians' Service.

Mr. Dobson, new manager of the Mount Vernon Sanitarium, spoke briefly on the new policies of the institution.

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* Address: 220 Montgomery Street, San Francisco. Telephone: EXbrook 3212.

The application for membership of Dr. William L. Cover of San Bernardino was approved.

Dr. Walter Cherry reported on the House of Delegates meeting in Del Monte. The most important item is a $10 assessment to be levied shortly.

The program of the evening was as follows: *Common Skin Diseases and Their Treatment,* by Dr. Paul D. Foster of Los Angeles.

The meeting adjourned at 9:40 p. m., following which refreshments were served.

Arthur E. Varden, *Secretary.*

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SAN JOAQUIN COUNTY

The regular meeting of the San Joaquin County Medical Society was held on Thursday, May 4, in the Medico-Dental clubrooms. The meeting was preceded by the customary supper meeting at the Hotel Wolf, at which Doctor Ross read a paper on some *Urogical Problems.*

The regular meeting was called to order at 8:30 p. m. by President Neill P. Johnson. The application of Dr. W. T. Auld was read and referred to the Admissions Committee. The Secretary of the Society briefly reported on the recent secretaries' meeting at Del Monte, April 30. Dr. Dewey Powell reported for the delegates to the California Medical Association Convention, telling us the progress of the California Physicians' Service and the creation of the Public Relations Council. The paper of the evening was presented by Dr. John A. Bacher of Stanford, who spoke on *Otorhinolaryngology.* The paper was illustrated with blackboard drawings and slides. This caused considerable and favorable discussion from the floor.

There being no further business to come before the Society the meeting was declared adjourned, and refreshments were served at 10:30 p. m.

G. H. Rohrbacher, *Secretary.*

CHANGES IN MEMBERSHIP

New Members (72)

Alameda County

Saul T. Hershkowitz

Los Angeles County

Charles B. Behrens
Arthur W. Buell
Reuben D. Chier
Z. Philip Cooper
Lewis Cozen
Herbert G. Crockett
Harri L. Davies
John B. Davis
J. James Duffy
John W. Elder
Samuel Yen Eng
C. B. S. Evans
George E. Fakehany
Gaylord L. Fisher
Hans Flieg
Joseph Goorwitch
William T. Grant
Powell W. Griffith
Michael M. Gurdin
John R. Hansen
Vernet H. Heinz
Harry J. Hoare
William J. Hogue
J. Russell Hughes
Irene M. Hunt
E. J. Joergensen
Roy W. Johnson
Jeremiah W. Kerner
Herbert D. Krieger
W. I. Laughon
C. A. Mann
J. P. McBride
William O. McDermott
Charles H. McMillen, Jr.
Colin B. McMullen
Roy F. Messinger
Theo E. Miller
Ralph M. Milliken
R. R. Montgomery
Harry W. Murphy
Oliver Roscoe Nees
Alonzo J. Neufeld
Alvirdo W. Pearson
Gordon Richardson
Buford B. Roberts
Frederich Rosenthal
A. George Sheftel
Charles Shickle
Cecil L. Shotwell
Leander W. Stark
Paul W. Tully
Charles J. Welker
Richard A. Westsmith
Trueman I. Wigim
Samuel Wolfson

Merced County

Gerald L. Crenshaw
W. W. Stadel

Monterey County

William F. Coughlin

San Bernardino County

Horace Sunderlin Eldredge

San Diego County

James R. Phalen

San Francisco County

Jerome P. Glukfeld
Henry Wise Newman
Morton J. Nyda
Hall Seely

Santa Barbara County

George H. Derieux
Douglas F. McDowell
Harold O. Nelson

Santa Clara County

Clement Arnold
Theodore Jones
James Sunseri

Sonoma County

Marion T. Webster

Transferred (2)

Joseph H. Boyes, from San Francisco County to Los Angeles County.

Emmett F. Kesling, from San Bernardino County to Los Angeles County.

In Memoriam

Day, Robert Verne. Died at Los Angeles, April 30, 1939, age 63. Graduate of the University of Southern California School of Medicine, Los Angeles, 1897, and licensed in California the same year. Doctor Day was a member of the Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

* * *

McKee, William Clifford. Died at Los Angeles, April 23, 1939, age 54. Graduate of Johns Hopkins University School of Medicine, Baltimore, 1913. Licensed in California in 1914. Doctor McKee was a member of the Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

* * *

Poage, Charles Allen. Died at Colusa, May 3, 1939, age 66. Graduate of Cooper Medical College, San Francisco, 1901, and licensed in California the same year. Doctor Poage was a member of the Yolo-Colusa-Glenn County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

* * *

Sellew, Paul Kibbe. Died at Los Angeles, May 5, 1939, age 53. Graduate of Yale University School of Medicine, New Haven, 1911. Licensed in California in 1916. Doctor Sellew was a member of the Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

* * *

Zantiny, William George. Died at Long Beach, April 12, 1939, age 62. Graduate of Cleveland College of Physicians and Surgeons, 1908. Licensed in California in 1925. Doctor Zantiny was a member of the Los Angeles County Medical Association, the California Medical Association, and the American Medical Association.

THE WOMAN'S AUXILIARY TO THE CALIFORNIA MEDICAL ASSOCIATION†

MRS. FREDERICK N. SCATENA..........................President
MRS. FRED H. ZUMWALT..............Chairman on Publicity
MRS. FRANK H. RODIN..Assistant Chairman on Publicity

News Letter

Dear Auxiliary Members:

The convention of the California Medical Association and its Auxiliary, held at Del Monte, has taken place. We are greatly indebted to Mrs. Lawrence M. Knox, Chairman of Convention, and her very able committee for the generous hospitality and splendid arrangements for the comfort and entertainment of the members and guests who attended the convention.

As this goes to press, the names of the newly elected officers and the reports of the convention had not reached me, therefore I regret very much that this information is not included in this issue. I hope it will be included in the July issue of CALIFORNIA AND WESTERN MEDICINE.*

Sincerely yours,
MRS. FRANK H. RODIN.

Component County Auxiliaries

Alameda County

The Doctor's Mother was the theme used for the program of the May meeting of the Woman's Auxiliary to the Alameda County Medical Association held at the Claremont Country Club. The wives and members of doctors' families met for luncheon at 12:30.

Mrs. I. O. Church, Program Chairman, arranged a delightful program which included songs by Julia Phillips Page, accompanied by Mary Barnard Jacobus; instrumental numbers by Misses Helen Shutes, Lawring Palmer, and Edgell Stoltz; a string trio, and readings by Miss Barbara Ann Ashley.

As this was the last meeting of Mrs. Frank Baxter's term of office as president, she was credited with a very successful year of increased interest and attendance.

The hostess of the day was Mrs. Louis Henry Dyke, Sr.

MRS. GRANT ELLIS, *Publicity Chairman.*

* * *

Los Angeles County

The April meeting of the Woman's Auxiliary was held at the Los Angeles County Medical Building at noon. The president, Mrs. William H. Leake, presided. Seventy-seven members and guests were present.

Mrs. Paul D. Foster reported on *Hygeia,* the health magazine, subscriptions.

Mrs. Harold E. Crow, Philanthropy Chairman, reported that she, assisted by Mrs. Otto Bames, delivered eighteen Easter baskets to indigent families.

Dr. Claud Buss, Associate Professor of International Relations of the University of Southern California, spoke on *The Present International Crisis.*

MRS. KARL VON HAGEN, *Publicity Chairman.*

Marin County

The Woman's Auxiliary to the Marin County Medical Society met for dinner on April 27 at the Sleepy Hollow Golf and Country Club.

Mrs. C. W. Clark reported on a meeting held by the League of Women Voters, at which plans for socialized medicine were discussed.

The Chairman of Philanthropy reported that braces were bought for a needy crippled child. An allowance of $1.50 a month to purchase art materials was given to a young girl patient in the tuberculosis ward of the county hospital. She also was provided with a bathrobe, slippers, housecoat, and other physical comforts.

Dr. C. A. DeLancey showed some very interesting colored slides and gave a talk on *Glandular Disturbances and Abnormalities.*

MRS. C. A. DELANCEY, *Publicity Chairman.*

* * *

San Diego County

The Woman's Auxiliary to the San Diego County Medical Society met for luncheon on April 11 at the University Club.

Dr. Floyd Bond gave an interesting talk and explained the *Intricacies of Ophthalmology.* Mrs. R. H. Pressman gave an inspiring talk on *The March of Medicine.*

The report of the Nominating Committee was read.

MRS. H. K. ALBERTSON, *Publicity Chairman.*

* * *

San Joaquin County

The March meeting of the San Joaquin Auxiliary was held at the home of Mrs. H. A. Chapman. The president, Mrs. G. K. Weaver, presided. Twenty-one members and two guests were present.

Dr. Dewey Powell discussed the *Health Plan of the California Medical Association* and gave a very clear picture of the details.

The legislation affecting the nursing profession was also discussed with much interest.

Delicious refreshments and a social hour were enjoyed at the conclusion of the meeting.

MRS. G. K. WEAVER, *President.*

* * *

Santa Barbara County

The attractive parish hall of Trinity Episcopal Church was the setting for the annual bridge tea given by the Woman's Auxiliary to the Santa Barbara County Medical Society on April 21. A profusion of spring flowers adorned the tea tables and other parts of the large room. One hundred and seventy members and guests attended.

Presiding at the tea tables were Mesdames Horace Pierce, Franklin Nuzum, Charles Stevens, and William Remfry Hunt. The young daughters of the members assisted in serving.

MRS. C. W. HENDERSON, *Publicity Chairman.*

* * *

Santa Cruz County

The Woman's Auxiliary to the Santa Cruz County Medical Society met for luncheon at the Pasatiempo Country Club on April 27.

At the conclusion of the meeting the members adjourned to the Woman's Club to hear Drs. A. R. Kilgore, R. S. Stone, and Otto Pflueger speak on the *Cure and Prevention of Cancer.*

The newly elected officers are as follows: Mrs. F. P. Shenk, president; Mrs. Henry Watters, first vice-president; Mrs. N. R. Sullivan, second vice-president; Mrs. Mahlon McPherson, corresponding secretary; Mrs. R. C. Alsberg, recording secretary; Mrs. O. C. Marshall, treasurer; Mesdames A. L. Phillips and A. J. Sambuck, directors.

MRS. R. C. ALSBERG, *Recording Secretary.*

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† As county auxiliaries of the Woman's Auxiliary to the California Medical Association are formed, the names of their officers should be forwarded to Mrs. Frank H. Rodin, Assistant Chairman of the Publicity and Publications Committee, 2457 Bay Street, San Francisco. Brief reports of county auxiliary meetings will be welcomed by Mrs. Rodin and must be sent to her before publication takes place in this column. For lists of state and county officers, see advertising page 6. The Council of the California Medical Association has instructed the Editor to allocate two pages in every issue to Woman's Auxiliary notes.

* Editor's Note.—Names of newly elected officers appear in the roster, on advertising page 6.

MISCELLANY

Under this department are ordinarily grouped: News Items; Letters; Special Articles; Twenty-five Years Ago column; California Board of Medical Examiners; and other columns as occasion may warrant. Items for the News column must be furnished by the fifteenth of the preceding month. For Book Reviews, see index on the front cover, under Miscellany.

NEWS

Coming Meetings

American Medical Association. (Date of next annual session to be decided.) Olin West, M. D., Secretary, 535 North Dearborn Street, Chicago, Illinois.

California Medical Association, Hotel Del Coronado, Coronado, 1940. (Date of next annual session to be decided.) George H. Kress, M. D., Secretary, 450 Sutter Street, San Francisco.

Nevada Medical Association, Reno, September 22 and 23, 1939. Horace J. Brown, M. D., Secretary, P. O. Box 689, Reno, Nevada.

Medical Broadcasts*

Los Angeles County Medical Association

The radio broadcast program for the Los Angeles County Medical Association for the month of June is as follows:

Thursday, June 1—KECA, 10:45 a. m., The Road of Health.

Saturday, June 3—KFI, 9:00 a. m., The Road of Health; KFAC, 11:30 a. m., Your Doctor and You.

Thursday, June 8—KECA, 10:45 a. m., The Road of Health.

Saturday, June 10—KFI, 8:00 a. m., The Road of Health; KFAC, 11:30 a. m., Your Doctor and You.

Thursday, June 15—KECA, 10:45 a. m., The Road of Health.

Saturday, June 17—KFI, 9:00 a. m., The Road of Health; KFAC, 11:30 a. m., Your Doctor and You.

Thursday, June 22—KECA, 10:45 a. m., The Road of Health.

Saturday, June 24—KFI, 9:00 a. m., The Road of Health; KFAC, 11:30 a. m., Your Doctor and You.

Thursday, June 29—KECA, 10:45 a. m., The Road of Health.

American Congress of Physical Therapy.—The eighteenth annual scientific and clinical session of the American Congress of Physical Therapy will be held on September 5–8, 1939, at the Hotel Pennsylvania, New York City. Preceding these sessions the Congress will conduct an intensive instruction seminar in physical therapy for physicians and technicians on August 30 and 31, September 1 and 2.

Physicians are urged to plan their vacation for these periods and bring their families to New York for the World's Fair. Ample time has been provided for during the convention to visit the Fair and to enjoy the various activities of America's metropolis.

While the convention proper will have numerous special program features of scientific interest, the added attraction of the World's Fair should make it extremely worth while for every physician to come to New York and spend a most profitable vacation.

The instruction seminar should prove of unusual interest to physicians and technicians. The clinics which comprise half the schedule make this course outstanding for its practical value. As in the past, outstanding clinicians and teachers will participate. Registration is limited to one hundred, and is by application only. For information concerning seminar and preliminary program of convention proper, address American Congress of Physical Therapy, 30 North Michigan Avenue, Chicago.

Medical Discovery May Be Greater Than Microscope.—The discovery of methods for producing radioactive substances which can be widely used clinically "probably will be of greater importance than the discovery of the microscope." This statement was made by Dr. William J. Kerr, retiring president of the American College of Physicians, following the presentation of new evidence on the usefulness of the radio-active substances at the annual meeting of the College in New Orleans recently. Doctor Kerr is head of the division of medicine of the University of California Medical School.

"These substances will have a tremendous influence on the study of human metabolism," Doctor Kerr said. "It is possible now to use radio-active elements which have been shown to combine themselves in chemical molecules, and to study their course in the human body. Practically all of the chemical substances found in or taken into the body can now be traced in their progress throughout the body by methods which have been developed in the physics laboratories of the world."

Doctor Kerr called special attention to the University of California cyclotron, which is used to make all of the known elements radio-active, and to Dr. E. O. Lawrence, its director and inventor. Doctor Lawrence delivered the convocation address at the New Orleans meeting and likewise made a demonstration there, showing how the work of producing radio-active substances can have a direct bearing on the advancement of medicine.

University of California Medical School Revives Old English Custom.—Because three young men in the University of California Medical School did such outstanding work in their classes, certain of the faculty members were prompted to revive the fine old English custom of "handing down the gold-headed cane" in special recognition of their efforts.

Under the old custom, which held for 136 years, the physician who was deemed the most worthy member of his profession in the British Isles, was given the cane, to keep until his successor had been named. Doctor Radcliffe was the subject of the first cane presentation ceremony in 1689. Four successors received the same cane—Doctors Mead, Askew, Pitcairn, and Baillie. Upon the death of the last named in 1825, the cane went to the Royal College of Surgeons, where it may still be seen in the College Hall, London.

In the University of California ceremony, Warren L. Bostick, a senior student, was given a cane somewhat similar to that which figured in the English ceremony. Seniors Edward Jones and William R. Rosanoff were each given copies of the earliest edition of a book by Macmichael, describing the cane ceremony and giving the history of its recipients. A new cane is to be presented to next year's honor graduate in the same manner.

As a special feature, Dr. Herbert C. Moffitt, clinical professor, emeritus, who made the presentation speeches, was also given a gold-headed cane in recognition of fifty years of service with the University. Doctor Moffitt was the "gold medal" graduate of the University with the class of 1889.

The old custom symbolizes the habit of English physicians of long ago carrying gold-headed canes, in the hollow heads of which they carried herbs to protect themselves from disease.

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* County societies giving medical broadcasts are requested to send information as soon as arranged (stating station, day, date and hour and subject) to California and Western Medicine, 450 Sutter Street, San Francisco, for inclusion in this column.

Technical Exhibitors at Del Monte Annual Session Present Three Prizes.—In order to create interest in the technical or commercial exhibits, the firms who had booths at the Del Monte session created a pool of $100, to be divided into three cash prizes: the first for $50, the second for $30, and the third for $20.

The contest was open only to physicians, it being stipulated that each physician who entered the contest should receive a card on which was printed the names of various exhibits. All cards showing that the physician had visited every one of the technical booths were then placed in a sealed box. On Wednesday evening, May 3, President-Elect Dukes took therefrom three cards. The first prize of $50 was awarded to Dr. William Booth, Coronado; the second prize of $30 went to Dr. C. E. Schultz, Castroville; and the third prize of $20 was won by Dr. Hiram M. Currey, Santa Ana. This action by the exhibitors excited much interest.

New York Polyclinic Medical School and Hospital. Dr. Walter C. Alvarez, Mayo Clinic, Rochester, Minnesota, read a paper on "The Patient Who Doesn't Get Well in Spite of Treatment," on Thursday, May 4.

The New York Polyclinic Medical School and Hospital, 341 West Fiftieth Street, New York, is inaugurating a combined full-time course in urology, covering an academic year (eight months), on October 1, 1939. It will comprise instruction in pharmacology; physiology; embryology; biochemistry; bacteriology and pathology; practical work in surgical anatomy and urological operative procedures on the cadaver; regional and general anesthesia (cadaver); office gynecology; proctological diagnosis; the use of the ophthalmoscope; physical diagnosis; roentgenological interpretation; electrocardiographic interpretation; dermatology and syphilology; neurology; physical therapy; continuous instruction in cysto-endoscopic diagnosis and operative instrumental manipulation; operative surgical clinics; demonstrations in the operative instrumental management of bladder tumors and other vesical lesions as well as endoscopic prostatic resection.

Graphic Medical Murals Presented to University.—A history of California medicine from the time that Sir Francis Drake witnessed the crude autopsy on his brother's body, to the present day of super-voltage x-rays, painted in heroic proportions on the walls of a medical amphitheater, were formally presented to the University of California at a special ceremony recently in the University hospital here. The presentation was made in Toland Hall, where the realistic murals occupy all of the free portion of the circular wall above the demonstration pit. The display is said to be unique in hospital history.

One-half of the room shows the development of medicine in Northern California and the other in Southern California. The earliest Indians are seen emerging from their sweat houses, or being worked over by the shaman, or medicine man. Gold Rush medicine, which often substituted pliers for forceps, and which used whisky as one of its chief anesthesias, is made the subject of a mural in the central background. Dr. Don Pablo Soler, Spanish surgeon of the late eighteenth century, is seen attending an Indian who had been gored by a bull. The transition from these early crude forms of medical attention to the highly specialized and scientific procedures of the present is skillfully made by the artist.

Another central panel shows the first hospital in California, a crude shelter put up at San Diego in 1789 to succor members of the Portola expedition. The incident of James Ohio Pattie, old California trapper, vaccinating a number of early Californians against smallpox, is also shown.

Pacific Coast Society of Obstetrics and Gynecology. The next meeting of the Pacific Coast Society of Obstetrics and Gynecology will be held in Portland, Oregon, on October 4 to 7, 1939.

For further information, write to T. Floyd Bell, M. D., Secretary, 400 Twenty-ninth Street, Oakland.

Plan School Health Program for University of California Summer Study.—Public health and public health nursing will have an important place in the curricula of the 1939 Summer Session at the University of California at Los Angeles, according to Dr. J. Harold Williams, Dean of the Session.

Dr. Richard Arthur Bolt, director of the Cleveland Child Health Association, will come to Los Angeles to instruct two courses in public health for the State University. Other members of the Public Health teaching staff will include Helen D. Halvorsen, Birdie M. Adair, and Ruth Endicott Lewis, a member of the Department of Social Work at Washington University in St. Louis, Missouri.

Information concerning the summer courses is available on request to the University's Summer Session Office, 405 Hilgard Avenue, Los Angeles.

Quarterly Dinner of the "Society of the Medical Friends of Wine."[*]—On Wednesday evening, May 24, at the St. Francis Yacht Club, San Francisco, the members of the medical profession, to the number of almost one hundred, gathered to hold their quarterly dinner. The speakers for the evening included Carl E. Bundschu, a renowned wine grower of Napa County, who spoke on the "Romance of California Wine," and Doctor Maynard A. Amerine, Assistant Enologist, Department of Viticulture, University of California, who addressed the members present on "Wine Growing in California: Its Present-Day Status and Future Objectives." Following this, members participated in an informal discussion on wine in medical practice.

A guest of honor was M. le Marquis Bertrand de lur-Saluces, owner of a celebrated French vineyard. His informal address was much appreciated.[†]

The object of the Society of Medical Friends of Wine is to stimulate scientific research on wine, develop an understanding of its beneficial effects, and encourage an appreciation of the conviviality and good-fellowship that are a part of the relaxed and deliberate manner of living that follows its proper use.

The pioneers or founders of the Society are: Doctors H. E. Alderson, R. E. Ashley, Lloyd Crow, M. A. Francoz, C. D. Leake, S. P. Lucia, C. P. Mathé, H. C. Moffitt, T. F. Mullen, Langley Porter, R. A. Yoell, and G. E. Ebright.

Dr. Charles P. Mathé is president; Dr. T. F. Mullen, vice-president; Dr. R. G. Flood, secretary; and Dr. M. A. Francoz, treasurer.

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[*] See CALIFORNIA AND WESTERN MEDICINE, April, 1939, on page 300.

[†] Mr. Chairman, Gentlemen, Friends of Wine!

My English is much too poor to allow me to make a speech. But I have only to look in my heart to tell you how glad I am to meet American friends of wine and, as a French wine grower, to let you know the great pleasure I'll have during my journey to get in touch with Californian wine growers. It is my first trip to the United States, and I feel delighted to at last have the opportunity to visit the great country and friend of my country.

The whole world, especially France, looks to California as the best known and most famous paradise, and I am now able to see how much this wonderful country deserves its universal reputation.

Bordeaux wines and my own wine are appreciated and drunk over here; I am extremely proud of it. But this can give me some right to say that California wines are excellent. They ought to be served on every table twice a day, and we should not be able to find any left on the market.

Louis Pasteur has written somewhere that "Wine is the most healthful and most hygienic beverage."

Drink California wine! I really believe those three words ought to be written and read everywhere.

Long live California, and California wines forever!

Press Clippings.—Some news items from the daily press on matters related to medical practice, follow:

Patterson Promises to Help Chiropractors

Stockton, May 27 (Special to the Chronicle).—Lieutenant-Governor Ellis Patterson today told the convention of National Affiliated Chiropractors of California that the present Administration would "do everything in its power to further an amendment giving the chiropractic profession the same rights and privileges extended to other members of the healing professions."

The amendment is soon to be presented by the chiropractors to the voters for their approval.—San Francisco *Chronicle.*

* * *

Initiative May Give Harsher Health Insurance*

By Chester Rowell

The vote of the California Legislature on the health insurance bill merely means that the vote of the people on it will be by initiative instead of by referendum. It was certain from the beginning that the matter would be referred to the people one way or the other, and the motion, by friends of the bill, to make the referendum provision a part of the bill itself, was no "last minute concession" or "subterfuge," as stated by epithet-seeking opponents, but had been the intention of supporters of health insurance, including Governor Olson, from the outset. If the bill had passed the Legislature, opponents would have invoked the referendum by petition, and supporters were entirely willing, instead, to provide it by legislative action.

* * *

The only practical issue, therefore, was which way the vote of the people should be taken, and the Legislature has determined that it shall be by initiative. Whether from the standpoint of supporters or of opponents of health insurance, this is decidedly the less desirable of the two choices, but the Legislature, under the impact of pressure groups, has made it, and those who regret this choice have nothing to do but accept it and meet it on that basis. This will be done.

* * *

From the standpoint of opponents, the disadvantage is that the initiative, since it will originate from the labor groups, may be more objectionable to them than the much more conservative compromise measure which alone could have passed the Legislature. If what they want is no health insurance at all, they would have the opportunity to defeat it by popular vote, under either method of submission. If their hope is that the initiative method will submit a more radical measure, which they would have a better chance of defeating, they must remember that conservative supporters of health insurance will do their best to urge that the initiative measure submitted be as conservative as possible, and that radical supporters may be as open to the argument, in presenting the measure to the people, as they were in presenting it to the Legislature, that a measure less radical than they desire would be more likely to secure the votes necessary to pass it. Or, in the alternative that the more radical supporters do present a measure putting more of the cost on employers and the State and less or none on labor, that might pass, too, and then the opponents would have to live with it. They would then wish that the vote had been on the more conservative legislative measure.

* * *

From the standpoint of supporters of health insurance, the initiative is the less desirable of the alternative methods, though they accept it if denied the other. In the first place, all but the extreme Left wing of them would themselves prefer the test on a moderate measure, such as, except for the pressure groups, could have passed the Legislature. And, in the second place, a measure passed by initiative is cumbersome to amend, as experience and changing conditions will require even in technical details. It would be better if the initiative could provide that future Legislatures could amend it by a two-thirds vote, subject of course to referendum, but it may prove impossible to induce those who will sponsor the initiative petition to include this provision.

* * *

Nevertheless, since the vote can now be taken only this way, it will be done. There will inevitably be a hot campaign, of education and miseducation, before the people, the Medical Association the central political group on the one side and the labor unions on the other. Neither of these groups has votes enough to pass or defeat a bill, so the result will depend on the votes of the rest of us. If there were any hope that the campaign would be conducted by sober argument, on the facts, this would be a welcome example of the democratic process. Experience when the matter was last before the people, and with the pressure campaign to influence this Legislature, indicates that, instead, there will be wholesale resort to slogans, epithets, and appeals to prejudice.

* * *

Hitler says this is the only way to appeal to the people, and there are Americans who share this view. Even if they were correct, they would at least not be democratic. This was not Abraham Lincoln's estimate of the intelligence of the people of his time, who had far less advantages of education and means of information. It would be an inestimable service to democracy if this coming debate in California could be conducted as Lincoln and Douglas conducted theirs in Illinois. Unfortunately, there seems little prospect of it.

Anyhow, this question will not down, and the first test comes in California. Once it may have been "academic"; now it is practical, with the State and National administrations and large groups of organized voters determinedly behind it. Even the medical profession, in California, now concedes the principle of insurance, though it ignores the lessons of experience in applying it. In a few years, health insurance will be taken as much for granted as it now is in the rest of the world, and as workmen's compensation is in America.—Editorial, San Francisco *Chronicle,* May 20.

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Ten Democratic "Noes" on Olson Health Bill

Sacramento, May 17.—Administration forces huddled today to decide what could be done to revive the compulsory health insurance bill promised to the voters when the Democrats were elected last November.

Apparently on the road to certain defeat in the Assembly, the bill, amended yesterday, was back on file today awaiting decision of administration leaders.

The one clause, by which the administration hoped to woo the votes of both branches, provided the bill would not go into effect until approved by a referendum vote in 1940, was defeated, 41 to 33.

Ten Democrat "Noes"

The vote was along non-partisan lines despite administration backing for the measure. Five Republicans voted for the amendment and ten Democrats voted against it, one of them being Democratic Leader Hugh P. Donnelly of Turlock.

Heated words were tossed back and forth as Assemblyman Ben Rosenthal, Los Angeles Democrat and author of the bill, charged the "medical trust" was attempting to put sponsors of the measure on the spot.

He charged dictaphones had been planted in the chamber to record every speech and that owners of the machines should be made to register with the clerk of the lower house.

3 Per Cent Pay Roll Tax

He won his point, but Republicans revealed the administration also had a stenographic recording of all proceedings. She, too, registered.

After the dictaphone controversy died down, the bill as amended was sent out for reprint, to be considered later.

As amended, the compulsory health insurance bill, to be financed by a 3 per cent pay roll tax at an annual cost to industry of $63,000,000, provides these things:

Exemption for agricultural workers, domestics, public, religious and charitable organization employees.

Defeat Predicted

All income classes are included, with those making more than $3,000 a year given cash reimbursement for hospitalization in private institutions.

In its present form, Democrats and Republicans alike predict the bill is dead.

Assemblyman Melvyn I. Cronin, San Francisco Republican, in urging the referendum provision be killed, said:

"The administration knows full well this bill will not pass both houses. The amendment is offered in hope they can convince some of us it will take us off the spot by giving the people the final say. It is rank subterfuge."

Selling Economic Security

Adding his opposition to the measure, Assemblyman Lee T. Bashore, Glendora Republican, said that to approve it would be to "sell our economic security for social security."

Upon the referendum amendment, the roll call was as follows:

Ayes—Atkinson, Bennett, Michael Burns, Cassidy, Collins, Del Mutolo, Desmond, Dills, Doyle, Gallagher, Gannon, Gilmore, Hawkins, Heisinger, Kilpatrick, King, Lore, Maloney, Massion, Meehman, George P. Miller, Pelletier, Reaves, Richie, Rosenthal, Salsman, Tenney, Turner, Voight, Weber, Williamson, Yorty, Peek.

Noes—Allen, Bashore, Hugh M. Burns, Burson, Carlson, Clarke, Corwin, Cronin, Crowley, Daley, Dilworth, Donnelly, Evans, Field, Fulcher, Garland, Green, Houser, Johnson, Kellems, Kepple, Knight, Kuchel, Leonard, Lyon, Eleanor Miller, Millington, O'Donnell, Phillips, Poulson, Redwine, Scudder, Sheridan, Stream, Thorp, Thurman, Walker, Waters, Watson, Weybret, Wollenberg.

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* For editorial comment, see page 394.

Not Voting—Andreas, Call, O'Day, Robertson, Sawallisch.—San Francisco *Call-Bulletin*, May 17.

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State Health Plan Faces Defeat

Final Voting on Measure Is Postponed

Assembly Accepts Many Exemptions, Limits Benefits of Program

Sacramento, May 17.—Facing almost certain defeat, Administration forces in the Assembly today postponed indefinitely a showdown over Governor Olson's proposed compulsory health insurance program after the House late yesterday rejected an amendment to permit the people to vote on the measure.

Assemblyman Ben Rosenthal, Los Angeles, Administration spokesman, said he would not seek a final vote on the bill until some time next week and that he was under no illusions about the issue.

"The medical trust seems too strong for us," said Mr. Rosenthal.

Prior to rejection of the amendment to submit the bill to the people the lower house accepted half a dozen other changes modifying the scope of the proposal. The amendments limited health insurance benefits to those eligible to unemployment insurance, exempting agricultural labor, public employees, domestics and workers of community chest agencies and religious organizations.

Many Exemptions

Another change exempted Christian Scientists and similar healing groups; a third sought to guarantee health insurance benefits to those earning more than $3,000 a year; a fourth removed a possibility of use of state funds for administrative purposes.

Assemblymen Melvyn I. Cronin, San Francisco; Charles W. Lyon, Los Angeles, led the fight against the amendment.

The 41-33 vote against the amendment was not considered a proper measure of the voting strength of the opposition to the bill.—San Francisco *News*, May 17.

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Legislature to Push Work as Payless Days in Offing

Issues of Unemployment Relief and Budget Expected to Come Up This Week

Sacramento, May 14 (AP).—Prospects of payless service after next Saturday heightened probability of action next week on the two major issues of the fifty-third session—unemployment relief and the 1939-41 budget—as the Legislature prepared to resume its work tomorrow.

Under Constitutional provisions Legislators are paid only for one hundred Legislative days, at $12 for each day of such service, the total being the $1,200 annual salary paid to members of the California Legislature. A resolution setting May 27 as date of adjournment is before the Assembly.—Los Angeles *Times*, May 15.

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Warning Given on Olson Health Plan

Del Monte (AP).—The California Medical Association received warning yesterday from its legislative representative Governor Olson's pending compulsory health insurance bill appeared to be gaining strength, but organized medicine had a "fighting chance" to defeat it in the Assembly.

Speaking of that and other measures affecting medical practice, Dr. Junius B. Harris, spokesman for the association in legislative matters, said the doctors were facing their "greatest fight" in the next few months.

Dr. Harry H. Wilson of Los Angeles was unanimously chosen president-elect, to take office in 1940. Dr. Lowell S. Goin of Los Angeles, was reëlected speaker of the house of delegates. Dr. Dewey R. Powell of Stockton was elected vice-speaker.

Dr. George D. Maner of Los Angeles, Dr. C. Kelly Canelo of San Jose and Dr. Frank MacDonald of Sacramento, were named district councilors. Elected councilors-at-large were Dr. C. O. Tanner of San Diego, Dr. Elbridge Best of San Francisco, and Dr. Frederick N. Scatena of Sacramento.—Riverside *Press*, May 4.

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New Group Health Insurance Plan Outlined to Doctors

Del Monte (UP).—Proposed costs and membership regulations of the new group health insurance plan advanced by the California State Medical Association in the first statewide move of its kind in the United States were announced at the State Medical convention.

The Board of Trustees of the California Physicians' Service, the incorporated association group under which the plan is to be operated, said final plans and actual operation of the plan "is a matter of weeks."

Membership at the outset will be limited to employed groups earning not more than $3,000 a year. WPA workers will be eligible. A 50 per cent signup will be required for groups of 1,000 or more; a 100 per cent for groups of less than 10; and a corresponding ratio for groups between these limits.

$2.50-$2.00 Monthly

Voluntary memberships will cost $2.50 or $2.00 a month. The $2.00 fee will apply when the individual assumes costs of the first two visits for any illness.

Patients may select any physician of the 4,300 who have already joined the service.

Beneficiaries will be entitled to not more than one year's medical treatment for any one illness or injury; and not more than twenty-one days' hospitalization with complete nursing, x-ray and laboratory service.

The Physicians' Service will not accept responsibility for injuries covered by workmen's compensation insurance, mental disease, alcoholism, attempts to commit suicide, or incurred as the result of lawlessness. The service will not pay for drugs.

Provision for Childbirth

Medical and hospital care for childbirth will be provided only after the mother has been a member of the service for more than two years.

The plan will go into operation after completing arrangements with hospital insurance groups already in existence and the setting up of physicians' fees.

Payment for physicians will be based on a unit fee, ranging from one unit for a "second office visit" to eighty units for a major operation. The value of the unit in dollars and cents was yet to be determined.

Operation Schedule

Tentative schedules provided such unit valuation as:

Appendicitis operation—50 to 60 units; cesarian operation—60 units; fractures—8 to 60 units.

Although limited at first to those in employed groups, California Physicians' Service officials said it was hoped eventually to accept membership from dependents of group employees and from individuals.

The plan is to be operated and run by the physicians themselves. Another plan, compulsory, however, advanced by the State Administration, is up for consideration by the Legislature.—Watsonville *Register-Pajaronia*, May 4.

* * *

Doctors Study Health Bill

A. M. A. Leaders Fear Opening of Door to Major Social Revolution

St. Louis, May 14 (AP).—Prospects that 40 to 60 million Americans may become eligible to tax-paid, or tax-aided, medical service was the main issue discussed informally today by physicians gathering here for the annual meeting of the American Medical Association. Upwards of ten thousand doctors are expected.

In the Wagner Bill, now before Congress, some leaders professed to see the opening of the door to a major social revolution.

Provides Vast Sum

The bill would appropriate $92,000,000 for 1940 in six classes of federal aid to states for medical care. In 1941 the money would be $103,000,000 plus "sufficient" to care for indigent and unemployed sick at that time coming under state networks yet to be set up and if they are approved. In 1942, $199,000,000 plus the same kind of "sufficient" funds states would contribute.

The principle on which the bill is based has been accepted by the American Medical Association itself, by other groups of physicians and by President Roosevelt's health counselors. The principle is tax money to help indigent sick.

Method Criticized

But how to do it is drawing criticism from doctors. They forecast dangers, from the Wagner Bill, running even to control of election of Senators in thinly populated states by federal health officials, to benefits, if the principle is wisely used, such as standards of universal health the like of which the world has never seen.

Main criticism of the bill: Three federal officials would control not only the money but directly and indirectly the kind of medical service in each state. Anything, up to a state paying for the sickness of everyone, is possible.

Favor Local Control

Only local control can be medically efficient and that is not provided for specifically. Care of the sick is for doctors and should not be controlled by public health officials. Administrative personnel is provided for without specification of its medical qualifications.

The house of delegates of the American Medical Association, governing body of American medicine, said Dr.

Morris Fishbein, editor of the American Medical Association *Journal,* will this week consider the issues of localized control.

The Wagner Bill would provide new hospitals. Critics declare existing hospitals are not fully used. The nation has five thousand x-ray machines in hospitals, and these are not yet used to capacity for those who could benefit.—Los Angeles *Times,* May 15.

* * *

Reported Medical Lack Challenged

Association Group Denies 40,000,000 Need Care

St. Louis, May 16 (AP).—The idea that 40,000,000 economically submerged Americans are without medical care was challenged before the American Medical Association today.

The committee study of 43,000,000 Americans was presented with the written opinion the number actually in medical need is nearer 40,000 than 40,000,000.

This statement referred only to persons not at present cared for in some manner. The report estimated that perhaps 10,000,000 persons among the 43,000,000 are receiving, as needed, free medical care direct from doctors.

The report was read by Dr. W. F. Brasch of the Mayo Clinic. It summarized the results of a survey of 747 counties in thirty-seven states made by local physicians.

Free Aid Told

Twenty thousand physicians replied to questionnaires. Of these, 17,000 reported free medical service to 2,611,451 persons. In addition, these same physicians reported giving 1,909,713 hours a year free service in hospitals.

The report considered this showing a good cross-section of the average and said that if it is then the estimates of $1,000,000 a day free service by American doctors is far too low.

The 17,000 physicians were only 25 per cent of the doctors in the territories canvassed. The report assumed the probability that the other doctors contribute free service in about the same degree and said that if this is true, then the number of persons served without cost, among the 43,000,000, is about 10,000,000 in a year.

Action Postponed

Action on the Wagner Bill in the United States Senate proposing federal subsidies for the indigent sick, was postponed until Wednesday. It was announced that representatives of organized medicine will go to Washington, May 25, to give the Senate Committee the views of the present meeting of the house of delegates of the American Medical Association on the act.—San Francisco *Examiner,* May 17.

* * *

Medical Association Attacks Health Act

St. Louis, May 18 (AP).—The American Medical Association, through its house of delegates, was lined up solidly today in opposition to the Wagner health bill as "contrary to the best interests of the American people."

A resolution, adopted by the 174 delegates in twenty minutes without a dissenting vote, held the Wagner Bill fails to make use of existing facilities for the sick poor and would impose federal control of spending for the sick.

As an alternative, the doctors proposed starting with existing facilities, expanding them and permitting states to ask for and get federal aid as needed.

The resolution adopted yesterday was in general terms, so couched to serve as a statement of principles to guide the thinking of doctors. The American Medical Association and federal authorities are in agreement on the basic principle, that tax moneys be used to help care for the indigent sick.

The bill, commonly called the "national health act of 1939," is an amendment to the social security of 1935 and is intended to make effective a national health program recommended by the inter-departmental committee to coordinate health and welfare activities.—San Francisco *Call-Bulletin,* May 18.

* * *

Medical Association Lists Bars to Socialized Medicine

New York, April 15.—Six reasons why the American Medical Association opposes socialized medicine were placed before the American Association for Social Security by Dr. Morris Fishbein, editor of the *Journal* of the American Medical Association, here today.

His first point was that American medicine opposes compulsory sickness insurance "because it is compulsory and represents another step toward the breakdown of American democracy."

Doctor Fishbein predicated his second point on the stand that compulsory health insurance so called was not "health" insurance, but "sickness" insurance, and declared that the tendency of such proposals was to do "little or nothing for preventive medicine."

Other speakers at the morning session were Miss Helen Hall, head worker of the Henry Street Settlement and President of the National Federation of Settlements, and Dr. Hugh Cabot, of the Mayo Clinic, Rochester, Minnesota.

Thirdly, Doctor Fishbein held that compulsory sickness insurance encouraged excessive attention to minor illnesses and complaints and "deficiencies in the care of more serious conditions."

"Compulsory sickness insurance exalts administration at the expense of patient and doctor alike," he said as his fourth objection. "The German system has for years employed more administrators than physicians. The reported costs of administration in various countries vary from 10 to 20 per cent. Costly buildings for administration multiply and hospitals deteriorate. Sickness insurance interferes with professional control of standards and introduces incompetent political control.

"Fifth, compulsory sickness insurance offers no contribution to the care of indigent. The majority of the expense in such systems is paid by the low income workers. The deductions of these costs from a wage already too small to do more than meet the necessities of life creates more sickness than the medical care provided can prevent or cure.

"Sixth, in the United States today our sickness and death rates are as low or lower than those of any other great country in the world. . . . Thousands of experiments are being conducted with the aid of the medical profession leading to new methods of distribution of any payment for medical service. The American Medical Association has opposed only these experiments which involved deterioration of the quality of service, inhibition of medical advancement, uncontrolled solicitation and seduction of patients, promises that were certain never to be fulfilled."—Boston *Christian Science Monitor,* April 18.

* * *

Bill Limiting Use of "Doctor" O.K.'d

(By International News Service)

Sacramento, May 16.—Before the Governor for signature today were two bills passed by the Legislature, regulating the practice of medicine, including one which would permit only physicians and surgeons to use the title "doctor" alone. Holders of other medical certificates would be required to explain after their title what field they were licensed to practice.

A bill by Assemblyman Melvyn Cronin of San Francisco would permit graduate medical students and internes to treat the sick and afflicted for only two years in hospitals and schools. After that time a certificate would be required for further practice.—Los Angeles *Times,* May 16.

* * *

Prenatal Health Test Bill Signed

Sacramento, May 10 (AP).—Governor Olson today signed a bill requiring prenatal examination of women for syphilis. A second measure which would require premarital examinations of a similar nature has been passed by the Senate and is now pending before the Assembly. Olson announced he would sign this bill also.—San Francisco *Chronicle,* May 11.

* * *

Traveling Clinics to Visit Migrants

Three "Samaritan wagons," each staffed with a doctor, a nurse and a sanitarian, left San Francisco yesterday to carry preventive medicine to migratory workers in the agricultural valleys of California.

These traveling health centers of the State Department of Health will start work in Kern, Tulare and Yuba counties. First aid and treatment for simple ailments will be given. The truck clinics are equipped to act as ambulances in emergencies. They will move from locality to locality with the workers.

Each worker will be immediately immunized against smallpox (430 cases of it so far this year) and typhoid. Blood tests will be taken and a survey of malaria conditions made. In any case of serious illness the patient will be referred to the Federal Farm Security Administration's medical service.—San Francisco *Chronicle,* May 16.

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Medical Loans Rank Second

Hartford, Conn., May 14 (UP).—A survey of the State Banking Department reveals that most persons secured small loans—maximum $300—during 1938: first, to pay off old debts; second, to meet medical bills, and third, to refinance old debts.

Other reasons, in their order, were to cover immediate business needs, and for clothing.

Small loan companies in Connecticut catered to 72,013 borrowers during the year and lent $9,976,381. Interest was charged at the rate of 3 per cent on the unpaid balance up to $100 and 2 per cent on the unpaid balance up to the maximum borrowable amount of $300.

Skilled workers represented 36.89 per cent of the borrowers; unskilled workers, 18.38 per cent; office and clerical workers, 12.41 per cent; federal, state, county and city employees, 7.37 per cent; proprietors, 6.35 per cent, and commercial and sales workers, 6.25 per cent.

The average loan in 1938 was $104.34, while in 1937 it was $98.83.

Small loan companies collected 88.67 per cent of collectible charges.—Los Angeles *Times,* May 14.

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Senate Hears Cure Defense

Committee Tables Bill Declared Aimed at Practitioner After Hearing San Bernardino Man

Examiner Bureau, Sacramento, May 16.—A Senate committee today heard of a "cure" for advanced hopeless cases of tuberculosis, and how it was concocted of secret compounds from "Nature's laboratories."

The story was narrated by C. E. Grier, chairman of the San Bernardino County Board of Supervisors, appearing before a public health committee to protest a bill aimed, he said, at E. C. Hurlburt, "the unlicensed practitioner to whom I owe my life." He told how Hurlburt's remedy had aided him.

So effective was his story that the committee tabled the bill. However, Hal Randal, special investigator for the State Board of Medical Examiners, testified that examination showed that Hurlburt's "cure" compounds consisted among other things of kerosene, oil of sassafras and yellow dye, applied externally.—San Francisco *Examiner,* May 17.

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Dr. Van Etten Next President of A.M.A.

Opposes Public Control of Medical Practice

St. Louis, May 18 (AP).—From the ranks of its general practitioners, the American Medical Association today chose 72-year-old Dr. Nathan B. Van Etten of New York as its president-elect to take office when the Association meets in New York in June, 1940.

Summoned before the Association's House of Delegates, which selected him unanimously, Doctor Van Etten responded with a call for education of physicians and patients to the "dangers of centralized control of medical practice" he said were found in the Wagner public health bill.

The delegates adopted a resolution yesterday opposing the bill, which would set up a system of federal subsidies for indigent sick.

The bill, Doctor Van Etten charged, would "destroy" the practice of medicine as it now is known and would turn over "the functions of the most highly educated group of professionals in the world to bureaus operated by adventurous amateurs."

Others Elected

Doctor Van Etten, born in Waverly, N. Y., received his medical degree at Bellevue Hospital College in 1890, and has been medical director of the Morrisania Hospital since 1929.

Dr. Rock Sleyster of Wauwatosa, Wisconsin, took over presidency of the Association for 1939-40 at the convention here, succeeding Dr. Irvin Abell of Louisville.

Dr. Alphone McMahon, president of the St. Louis Medical Society, was elected vice-president of the Association to serve during the current year. He won by a vote of 93 to 42 over Dr. Louis J. Hirschman of Detroit.

Other officers were reëlected including Dr. Olin West, Chicago, secretary and general manager; Dr. Herman L. Kretschmer, Chicago, treasurer; Dr. H. H. Shoulders, Nashville, Tenn., speaker of the House of Delegates, and Dr. R. W. Fouts, Omaha, Nebraska, vice-speaker.

Atlantic City Wins

Atlantic City, New Jersey, was chosen over Philadelphia for the 1942 convention. The 1941 meeting will be held in Cleveland. . . .—San Francisco *Examiner,* May 19.

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Three Agencies of Four Put Okeh on Health Unit Plan

The long-talked-of public health service for Sutter and Yuba counties seemed to be assured this week when three of the four governing bodies voted to enter into agreement to include the plan in their budgets for the coming year. The Yuba County Board of Supervisors and the Yuba City Council voted it unanimously and the Sutter County voted it four-to-one. . . .—Yuba City *Independent Farmer,* May 5.

Coronado Gets Medical Parley

Two San Diegans were elected by the California Medical Association at Del Monte yesterday, Coronado was selected for the 1940 meeting place and delegates heard a San Diego Assemblyman's hospital bill termed a "screwbox" measure.

Dr. C. O. Tanner, San Diego, was elected a councilor-at-large. Dr. Lyell C. Kinney, San Diego, was chosen a delegate to the American Medical Association convention, The Associated Press reported.

In an address to the medical men, Dr. Junius B. Harris, legislative spokesman, said Assemblyman Paul Richie's bill requiring hospitals to supply "full service," without discrimination, to all patients and those who treat them, was a "screwbox" measure. The bill would compel the hospital to provide the patient and doctor with an advance price list of all service and supplies ordered by the patient or attending physician.

Dr. Harry H. Wilson, Los Angeles, unanimously was named president-elect. Dr. Lowell S. Goin, Los Angeles, was reëlected speaker, House of Delegates, and Dr. Dewey R. Powell, Stockton, vice-speaker.

Dr. George D. Maner, Los Angeles; Dr. C. Kelly Canelo, San Jose, and Dr. Frank MacDonald, Sacramento, were elected district councilors. Dr. Elbridge Best, San Francisco, and Dr. Frederick Scatena, Sacramento, also were named councilors-at-large.

With Doctor Kinney, Doctors Goin and Best were elected delegates to the American Medical Association convention.—San Diego *Union,* May 4.

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A.F.L. and C.I.O. Back Wagner Health Plan

Washington, May 11 (AP).—American Federation of Labor and Committee of Industrial Organization officials testified today in support of a proposal by Senator Wagner, Democrat of New York, for an expanded federal health program, while a representative of the Pennsylvania Medical Society opposed it as creating "a danger of breaking down Democracy in this country."

The witnesses testified at a Senate Labor Committee hearing on legislation which would provide federal grants to states for various health activities.

"In Germany in 1850 they started these things, and what is it now—a dictatorship," Dr. C. L. Palmer of Harrisburg, chairman of the Pennsylvania society's committee on public health legislation, asserted.

Lee Pressman, counsel for the C.I.O., attributed opposition to the bill to a "reactionary group of officials of the American Medical Association."

Matthew Woll, representing the A. F. of L., urged enactment of the measure, contending that "the cost of medical care should be lowered so that it is within the reach of that large part of the population which has less than $1,500 income."

Woll asked that administration of old age insurance, the national employment service, unemployment compensation and health insurance be placed under the Department of Labor.—Sacramento *Bee,* May 11.

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State's Compensation Plan Founder Opposes Olson Bill

Will J. French Warns Against Proposal to Create Industrial Insurance Monopoly

Sacramento, May 21 (Exclusive).—Will J. French, who served on the State Industrial Commission for approximately twenty years under five Governors and who was one of the founders of California's workmen's compensation system, has issued a warning against the proposal to create by law a monopolistic state compensation fund.

Governor Olson is supporting a bill pending before the Assembly Insurance Committee to give a monopoly to the state compensation fund and to eliminate the private carriers in the writing of workmen's compensation insurance.

In a letter to Assemblyman Gardiner Johnson, Berkeley, French declared that but "for the heavy hand of politics," the state compensation fund would have returned to policyholders a greater sum than the $30,800,000 returned since January 1, 1914.

He said that "there is a certain stability given by the prevailing system because of competition between the private insurance companies and the state fund."

French pointed out that when the state fund was planned in 1913, the three commissioners were divided as to recommending a monopoly and that his vote decided the controversy.

"Later on," he said, "the commissioners agreed that the wisest course had been followed."—Los Angeles *Times,* May 22, 1939.

100 Million Tax Seen If Insurance Bill Passes

North Coast Council Opposes Compulsory Insurance Bill

State levies of one hundred million dollars a year would be required to finance the compulsory health insurance plan now awaiting action by the California Legislature, members of the North Coast Council Taxation Committee—one of the major State Chamber of Commerce committees meeting here today—pointed out following their meeting.

Discussion of the health insurance plan featured the Taxation Committee's session during the morning. H. H. Sawyer, chairman, presided at the meeting, at which a bulletin recently compiled by the State Chamber on the plan, was read and discussed at length.

Of the $100,000,000 annual tax levy, $80,000,000 would be raised by new pay roll taxes and new state or federal taxes, the committee pointed out. This amount would go into a medical benefit fund, and $20,000,000 would be shifted from the employee pay roll taxes now going into the unemployment reserve fund would be shifted to a new disability benefit fund, according to the State Chamber's bulletin, which analyzes Assembly Bill 2172.

From the fund of $80,000,000 to be so created, the state would undertake to provide all medical care and medicines, and specified dental, hospital and nursing care, to all employed workers receiving less than $3,000 per year and their dependents.

The State Chamber bulletin says:

"The most important provisions of the measure would provide for a system of compulsory health insurance for about 1,800,000 employed workers and dependents. Under this act, the state would collect by new taxation about $80,000,000 annually, to go into a state medical benefit fund.

Employees Provide One-Third

"Employees would provide one-third of this fund by means of a 1 per cent pay roll tax on earnings. The remaining two-thirds would be provided by the general public, one-third to be raised by a 1 per cent employer pay roll tax, and one-third by other new taxes which are not specified in this measure.

"For about 70 per cent of the state's population the existing relationship between doctors and patients would be entirely changed. All licensed physicians and surgeons would be permitted to register and contract with the state to furnish medical and surgical care for this group of workers and their dependents.

"A doctor's payment would not be on the present basis of fees for various services actually rendered to individual patients, but each doctor would be paid a uniform flat rate of so many dollars per year for each person on his medical list, regardless of the amount or quality of services rendered."

The State Chamber of Commerce, at a recent meeting of its Board of Directors, voted to oppose this health insurance measure, raising particular objection to the method of finance proposed, and the addition of new pay roll taxes on industrial and business employers.—Santa Rosa *Republican*, May 5.

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Health Insurance Bill Loses First Test in Assembly

Administration Forces Beaten on Referendum Amendment; Final Defeat Is Predicted

Sacramento, May 16.—By a vote of 41 to 33 the Assembly late today gave positive indication it will defeat the compulsory health insurance bill sponsored by Governor Olson when the measure is up for final action.

The decisive vote came on an amendment by administration forces to provide that the bill would not become effective until it had been approved by the people. Plans were to submit it to the voters at the 1940 general election.

The amendment proposing a referendum was offered in an effort to stave off defeat for the administration forces. Assemblyman Ben Rosenthal, Los Angeles, author of the bill and an Olson leader, presented the amendment.

Termed "Evasive"

Characterizing the amendment as "a subterfuge and an evidence of insincerity," Assemblyman Melvin I. Cronin, San Francisco, one of the opponents of the bill, declared the sponsors of the health insurance program should submit it as an initiative measure if they wished to put it before the people.

Assemblyman Charles W. Lyon, Los Angeles, joined in urging defeat for the amendment, declaring the "orderly way for the Legislature to submit such a program is by a constitutional amendment which would require the votes of fifty-four members of this body." He also branded the amendment as "evasion and a subterfuge."

Prior to the vote on the amendment a series of other changes were made in the bill. The most important exempted members of the Christian Scientist faith from the provisions of the bill. Another provided for cash reimbursement and hospitalization for those who earn more than $3,000 annually, giving them the same credit as those in the brackets between $300 and $3,000. Other amendments excluded all persons not included under provisions of the unemployment reserves act.

Assemblyman Rosenthal admitted that his bill faced defeat. He declared the "medical lobby" had been too strong for his forces.

The bill provides for the establishment of a compulsory health insurance system for persons earning between $300 and $3,000 per annum, financed by a 1 per cent contribution from employer, employee and state. Physicians would register under a panel system. The plan would be placed within the present unemployment reserves for administrative purposes.—San Francisco *Chronicle*, May 17.

LETTERS

Subject: Statute of limitations.*

(COPY)

May 9, 1939.

Dear Doctor:

Yours of May 1 addressed to the California Medical Association has been referred to me for reply. Ordinarily, a claim for medical services would be barred by the statute of limitations if pleaded, unless suit is brought within two years from the date of rendition of services. Therefore, it is well to either commence a suit within two years from date of rendition of services or secure a promissory note or a written acknowledgment of the debt before the two-year period passes.

Under certain circumstances the statute of limitations on a suit to recover professional fees is four years, but it is not advisable to wait more than two years and risk the interposition of the two-year statute as a defense.

Normally a claim for negligence (malpractice) against a physician can be barred by pleading the statute of limitations if the action is commenced more than one year after the alleged negligent action or omission occurred.

I am stating the general rules. There are exceptions to both, particularly in malpractice cases where the alleged negligent act may be a continuing one, *e. g.*, failure to remove a sponge.

Very truly yours,

HARTLEY F. PEART.

Subject: Medical advice over the radio.

(COPY)

JOINT COMMITTEE ON PROFESSIONAL RELATIONS
OF THE
MEDICAL SOCIETY OF NEW JERSEY
AND THE
NEW JERSEY PHARMACEUTICAL ASSOCIATION
Trenton, New Jersey,

May 5, 1939.

To the Editor:—The Joint Committee on Professional Relations of the Medical Society of New Jersey and the New Jersey Pharmaceutical Association at a recent meeting passed the following resolution, which has been endorsed by the Medical Society of New Jersey and the New Jersey Pharmaceutical Association:

Resolved, That the Joint Committee on Professional Relations request the Medical Society of New Jersey and the New Jersey Pharmaceutical Association to enter a formal protest against the prescribing of medicines and the giving of medical advice on the radio, with the exception of such broadcasts on health matters as are given under the auspices of recognized associations of licensed physicians or Federal, State and local health departments; and be it further

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* Copy of a letter from General Counsel Hartley F. Peart to a member of the California Medical Association.

Resolved, That such protest be sent to the broadcasting companies and the Federal Communications Commission.

The members of your organization have doubtless been moved to protest against the type of medical advice that is furnished over the radio in connection with patent medicine broadcasts. This type of promotion in behalf of self-medication is becoming more subtle and radio announcers are endeavoring to tie up their advertising message with some complimentary reference to the medical and pharmaceutical professions.

We believe the time has come for concerted action to curtail this type of activity, in behalf of the lay public which is unable to recognize the difference between correct medical advice and commercial propaganda, and we trust, therefore, that your organization may pass a resolution similar to the one noted above and send it to broadcasting companies and the Federal Communications Commission at Washington, D. C. . . .

319 Trenton Trust Building.

Very truly yours,

JOINT COMMITTEE ON PROFESSIONAL RELATIONS.
Prescott R. Loveland, *Secretary.*

Subject: Certain reports—To be had on application.

THE AMERICAN PUBLIC HEALTH ASSOCIATION

New York, N. Y., May 11, 1939.

To the Editor:—The American Public Health Association has recently adopted five reports dealing with educational qualifications of public health statisticians, school health educators, public health engineers, sanitarians, and subprofessional field personnel in sanitation. A copy of each report is sent you in the hope that you will find it possible to carry an item in your Journal announcing their availability. These reports are distributed free of charge in the hope that they will serve a useful purpose in raising the educational standards of professional public health personnel. Copies may be secured from the Book Service, American Public Health Association, 50 West Fiftieth Street, New York, N. Y.

Your coöperation will be greatly appreciated.

50 West Fiftieth Street.

REGINALD M. ATWATER, M. D.,
Executive Secretary.

Subject: Benzyl benzoate, not Benzoyl benzoate: A correction.

(COPY)

May 11, 1939.

To the Editor:—My article in the April issue, page 265, of CALIFORNIA AND WESTERN MEDICINE, "A Comparative Study of Sodium Thiosulphate Treatment of Scabies as Compared with Benzyl Benzoate," has an error which is of great importance (and which was not noted at the time I corrected the proofs).

Instead of benzoyl benzoate, as stated in the article, it should be benzyl benzoate. These two drugs are entirely different, benzyl benzoate only being active in the treatment of scabies.

I would appreciate it very much if you have any means of making a correction in your next issue of CALIFORNIA AND WESTERN MEDICINE.

Very truly yours,

ARNE ELY INGELS, M. D.

MEDICAL JURISPRUDENCE†

By HARTLEY F. PEART, ESQ.
San Francisco

EXTENSION TO NURSE OF OBLIGATION TO KEEP COMMUNICATIONS CONFIDENTIAL

In the April issue of CALIFORNIA AND WESTERN MEDICINE, the author treated under the title, "Legal and Ethical Protection Given to Facts Made Known to a Physician in Confidence," various phases of the obligation resting upon a physician to keep inviolate, facts learned from or about a patient during the existence of the physician-patient relationship. The following is a brief summary of an opinion of a California District Court of Appeal upon the issue: How far, if at all, does the obligation of confidence bind a physician's assistants? The facts of the case in which the opinion was rendered (*Kramer* vs. *Policy Holders' Life Ins. Assn.,* 5 Cal. App. (2nd) 380) are interesting though recurrent.

Plaintiff brought suit, as beneficiary, upon an insurance policy in which his diseased wife was the insured. On February 2, 1930, in her application for the policy, deceased stated that she had consulted a doctor within three years for a minor operation of the breast, but had fully recovered from such operation and that her present state of health was good.

On July 2, 1930, the insured visited the Coffey-Humber Clinic in Los Angeles. At that time and place, a staff physician, in the presence of his stenographer, took the patient's history and made a physical examination. From the patient he learned, among other things, that between the 11th and 12th of December, 1929, less than two months before the acceptance of her application for insurance her right breast had been removed because of cancer. Also that, at the time of the removal of the right breast, she was informed by the doctor that there was already a tumor of the left breast, and many other facts as to her previous state of health. The physical examination revealed to the doctor that the insured had an extensive spread of cancer, originating in the right breast, which, in his opinion, had been in existence in her system for in excess of two years.

To show that the representations made by the insured in her application for insurance were false and untrue, and known by her to be so, the company attempted to introduce the testimony of the physician as to what he learned in taking the patient's history and making his examination. The appellate court in sustaining the act of the trial court in ruling out the testimony of the physician on the ground that the physician had gained such information in professional confidence, extended its opinion to include a discussion of the position of the physician's stenographer in relation to the confidential communications, which discussion is the latest expression of a California appellate court on this phase of law.

Due to the fact that the stenographer in this instance kept the registry of all appointments, got the patient ready, took off her waist so as to get at her chest, and remained during the examination to take down in shorthand all that the physician discovered, it can be said that her duties resembled those of an office nurse.

The Court said:

> As already suggested, the mere presence of a third person does not mean that the privilege has been waived as to the doctor. The capacity in which the third person is present makes a real difference. There are three lines of cases in this respect. One in which a third party is present, whose

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† Editor's Note.—This department of CALIFORNIA AND WESTERN MEDICINE, presenting copy submitted by Hartley F. Peart, Esq., will contain excerpts from and syllabi of recent decisions and analyses of legal points and procedures of interest to the profession.

presence is in no respect necessary, and this is obviously apparent to the patient. In this type of case some decisions hold that both the physician and the third party may testify, and some that the third party only may testify. The second line of authorities applies to that type of case in which a third party is present and the patient has a right to believe that said party is present as one of the agents or assistants of the physician in charge. In this class the authorities agree that the attending physician cannot testify, but as to the third persons they divide themselves into three groups. The first group for convenience may be referred to as the co-professional class, in which it is held that when said third party being a licensed doctor is a consulting doctor; or an assistant doctor; or the partner of a doctor; neither the attending doctor nor his co-professional may testify.

The second group for convenience may be called professional agents, in which it is held that when a nurse or other third person is actually working as agent and assistant under the supervision of the doctor in charge, such agent is covered by the privilege as well as the doctor. A study of the cases in this group, however, shows that the statute had been extended to include nurses. (*Culver* vs. *Union Pac. R. Co.*, 112 Neb. 441 (199 N. W. 794)). Such not being the fact here, we will not discuss this group, although the Culver case, *supra*, speaking without regard to the amendment of the statute to include nurses, does suggest that the statute should as a matter of law be extended to the professional assistant. We express no opinion on the suggestion, since none is necessary to a decision of this case.

The third group holds that in situations where the presence of a third person is apparently necessary, the doctor is covered by the privilege, but the necessary third person is not.

This third general line of authority applies to those cases in which a nurse or other third person, as separate individuals in independent positions and not as incidents to a conference with the doctor in charge, receive medical confidence. All of these cases are to the effect that such confidence is not within the privilege.

An analysis of the facts in the cases coming within this group and the rules therein enunciated demonstrates the extreme jealousy on the part of practically every court which has been asked to construe a statute similar to our own, to guard the privilege and to save it from being frittered and nibbled away because of factual situations which do not come within the letter of the statute, but are plainly embraced within its intent and spirit.

Further on the Court stated:

The only California case to which our attention has been called which is at all related on the facts is the case of *Horowitz* vs. *Sacks*, 89 Cal. App. 336 (265 Pac. 281). In that case the Court says at page 344: ". . . All of the information the witness obtained from his patient was obtained in the presence and hearing of third parties, the husband, mother, and brother of the patient. Such communications of the patient were not confidential and therefore were not privileged." It will be discerned, however, that the Sacks case is easily distinguished in at least one vital element, even if there were no other elements in that case which do distinguish it. In the instant case the communications were made in the presence of a necessary third party who was acting as the agent of the doctor, under his direction and supervision and under such circumstances that the patient had every right to conclude that the presence of such third party was necessary. In the Sacks case the information was given in the presence of nonprofessional and unnecessary third persons, in so far as the attendance of the doctor was concerned. It is apparent that although called a stenographer, the third party in the instant case was in reality and did perform all the duties of an office nurse. This distinction calls for the application of a principle different from that applicable when a third party has, strictly speaking, no business being present. (See cases *supra.*) The statement in the Sacks case must, however, be construed in relation to the facts to which it was applied. As a general statement purporting to be the law in all cases, it cannot be accepted, and the cases cited to support the general statement made in the Sacks case do not so hold. It is quite clear that the Court in the Sacks case did not so intend it, when the statement is read in the light of the authorities cited to support it, and the facts to which it was applied. The cases referred to in the Sacks case and others called to our attention by appellant with practical unanimity are decided on the doctrine that the communications made and testified to were not in fact confidential, and were not intended to be so by the person making them, and this conclusion is reached by the Court in those cases not merely because the nonprofessional unnecessary third party was present, but on additional facts such as the voluntary nature of the statements, their irrelevancy to the confidential relationship, the fact as to whether the relationship existed at all, and other important circumstances.

In *Southwest Metals Co.* vs. *Gomez, supra,* the Federal Circuit Court of Appeals of this district had before it a parallel situation—the construction of an Arizona statute similar to our own. It was there held that the nurse could testify, but that the doctor could not. We are satisfied that the presence of the stenographer did not operate to waive the privilege, in so far as the doctor was concerned, and that the motion to strike was correctly granted. Since the stenographer was not called and did not testify, we are not called upon to determine whether she could testify.

The opinion above referred to clearly shows that the law is still unsettled in California in regard to whether or not a patient can rely upon protection being afforded to his or her statements when a third party is present. If the presence of a third party or parties is unnecessary, that party is not bound by the rules governing confidential communications. Should the third party be a professional agent, such as a nurse, such agent would probably be bound as is the doctor, but the point is still unsettled.

SPECIAL ARTICLES

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1. *Proposed National Health Program.*
2. *Report on 1938 Morbidity and Mortality.*
3. *Lowest Infant Mortality Rate Recorded for California.*
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PROPOSED NATIONAL HEALTH PROGRAM*

The assumptions upon which the structure of the proposed national health program is based are essentially fallacious.

1. It is assumed that the health of the people of the United States is neglected and of low order. The record is consistent to the contrary effect. The national health was better in 1938 than in any past year and has been improving steadily for the past ten years. No other 130,000,000 people in man's history have enjoyed so favorable an experience of life as the people of the United States do today.

2. It is assumed that 40,000,000 people in the United States are unable, and in fact do not get the medical care they need. The evidence of physicians, medical institutions and widespread human experience convinces us that those who need medical care and want it are receiving it, except where poverty and sparsity of population groups have failed to attract physicians to settle among them.

3. It is assumed that large expenditures of federal money will make great improvements in health and care of the sick at the same time that economic and social inequalities of serious degree remain uncorrected.

Experience suggests that in the United States expenditures for health and care of the sick have been increasing at as rapid a rate as the several states, cities, and counties can afford, and as fast as trained personnel can be had to carry out the technological procedures.

Whatever money is granted from Washington to states has been taken first out of the states and to that degree has deprived states and local health jurisdictions of resources which they know better how to spend than do officers of federal departments.

4. It is assumed that there is a spontaneous, informed, widespread demand by the laity, particularly the unemployed, unemployable, relief, and subsistence level wage-earners for an amount and quality of medical care and health protection not now available to them.

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* Summary of a statement by Haven Emerson, M. D., given at a dinner meeting, March 15, 1939, New York City.

The record would point to ingenious, persistent, organized propaganda, and costly federal publicity and promotion, to create a sense of dissatisfaction with the present medical services on the part of the indigent and low-income groups, who have, almost without exception, shown grateful appreciation for and confidence in the care provided now through existing voluntary and tax-supported institutions and agencies for the sick, and by the individual physician.

5. It is assumed that the health officers and organizations of states and subordinate jurisdictions of civil government, authorized, appointed, trained and qualified for expert services for health protection. can by virtue of federal grants, and under federal regulations and restrictive standards, deal expertly with the elaborate services required for the sick in hospitals, dispensaries, and individual homes, in spite of the lack of clinical qualifications or familiarity with diagnosis and treatment of disease possessed by these same state and local health officers.

Familiarity with this professional group convinces me that the health services of cities, counties, and states will deteriorate if the major responsibility and expenditures of health departments are for care of general sickness.

6. It is assumed that the education of physicians, sanitarians, nurses and other associated professional personnel can be extended and hastened better by federal subsidy of individuals and favored institutions than by the independent development of professional educational institutions under their present auspices and with their present resources.

There is no experience, accomplishment or leadership in the field of professional education among the officers or employees of the Federal Government of a quality equal to what is to be found in the nonpolitical state and endowed institutions in the United States today.

Every draft of tax funds from the states to be distributed according to some federal formula or departmental criterion starves and hampers the states which have means to carry their own loads and share with their neighbors, and replaces self-dependence and local initiative and resourcefulness in the backward and impoverished states by encouraging their dependence upon federal doles for purely local and state functions for care of the sick and for public health.

The device of federally abetted state compulsion of sickness insurance schemes upon certain classes of the population, who are especially dependent because of low earning power and lack of facilities for effective voluntary association to carry the cost of sickness, represents a mere duplication of the unsatisfactory systems of medical services developed in the era of social deception and central governmental dominance by Bismarck and Lloyd George, neither of which has brought adequacy, superiority or professional or lay satisfaction to Germany or Great Britain.

7. The United States is now at the head of modern nations in the performance of medical function for social ends. The structure created by local and state government and society is effective, delicately adjusted, well understood by the communities concerned and improving as fast as human resources and funds permit. . . .

The undertakings provided for in the Wagner Bill will set back rather than advance public health, will destroy the strongest motives of self-reliance and local responsibility by dependence upon remote federal officers unfamiliar with the respective needs, ambitions, and capacities of the widely varied state populations and governments. . . .

Nothing but a threatened calamity of catastrophic proportions could justify such a revolution of control over functions reserved by the Constitution to the police powers of the states.

Calamity of an enduring kind to the applications of the medical sciences for social ends is likely to follow any general acceptance of the policies and programs provided for in the Wagner Bill.

REPORT ON 1938 MORBIDITY AND MORTALITY*

Measles.—The measles epidemic of 1938 in the United States was the greatest in recent times, according to complete reports just received from state departments of health, the number of cases being more than two and a half times that of 1937 and twice the median for the preceding five years. The number of deaths from measles was thrice the figure for 1936 and 1937.

The epidemic was unusually widespread, with only the New England and Pacific Coast areas fairly free. Thirty-one states reported increased death rates from this cause.

Smallpox.—Only this disease and smallpox were more than usually prevalent during 1938, according to a statement from the United States Public Health Service (*Public Health Reports,* May 5, 1939). The latter disease showed twice the number of cases of the preceding five-year median.

"With the possible exception of Mexico," said the statistical analysis, "the United States has one of the highest case rates of smallpox reported in North America and Europe. The incidence of the disease is unknown in most parts of South America, Africa and Asia in view of the success of other nations in practically stamping it out. The situation prevailing in this country reveals a curious indifference to the existence of a disease which can be readily controlled by well-known methods.

"The disease is relatively rare in all parts of the country except the Great Plains and Pacific Northwestern States. Starting there in 1938, the outbreak spread slowly until many states outside this area reported a higher case rate than usual. The incidence began to decrease during the last half of 1938, but it is still well above the average."

Diphtheria.—Below the five-year median are the number of cases of diphtheria, influenza, meningococcus meningitis, poliomyelitis, scarlet fever, and paratyphoid fever. Diphtheria, while slightly higher than in 1937, was still about one-fifth less prevalent than the preceding five-year median.

Mortality Rates.—The mortality rates reported are based on preliminary data covering about 90 per cent of the country's estimated population. They indicate that the general death rate will be the lowest on record, resulting in large part from the unusually low death rates for the principal respiratory diseases, influenza, and pneumonia.

The rates reported for these diseases during 1938 were the lowest on record: typhoid and paratyphoid; scarlet fever; diphtheria; poliomyelitis; tuberculosis; malaria; pellagra; diseases of the digestive system; pregnancy and childbirth; nephritis; and epidemic cerebrospinal meningitis. In addition, mortality rates from influenza, pneumonia, and accidental causes were the lowest in recent years.

For the ninth consecutive year a decline in the maternal mortality rate was noted.

For the first time since mortality statistics have been available for any appreciable number of states, the death rate from tuberculosis is now shown to be less than fifty per 100,000 population.

"Judging from the decline in the mortality rate," said the Reports, "the widespread safety campaign aimed especially at preventing fatal automobile accidents has achieved appreciable success. The mortality rates were decreased 20 per cent during 1938, and the rate 23.9 per 100,000 population was the lowest since 1932. The death rate from all accidents decreased 12 per cent as compared with the rate for 1937."

Two important diseases of childhood, also, diphtheria and scarlet fever, continued to decline in importance. The infant mortality rate continued to decline, reaching a new low of forty-eight deaths per one thousand live births.

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* From the United States Public Health Service.

Twenty states reported a higher death rate from whooping cough and cerebral hemorrhage than in 1937; twenty-four states, a higher death rate from diabetes.

Cancer and heart disease were the only major causes of death for which a higher rate was recorded in 1938. As this increase has been reported annually for several years, it is probably one which results, in part at least, from a general aging of the population.

LOWEST INFANT MORTALITY RATE RECORDED FOR CALIFORNIA

There were 4,450 infant deaths registered in California in 1938 as compared with 5,066 such deaths in 1937. The rate dropped from 53.7 in 1937 to 43.8 in 1938. Since 1920, California's infant mortality rate has been almost cut in half, and in some communities of the state infant mortality rates have been achieved that compare favorably with those of any communities anywhere in the world. If it were not for the large numbers of Mexican infant deaths, California's record in saving the lives of babies would be particularly outstanding. As a matter of fact, the infant mortality rate for the white race in California last year was but a little more than thirty-six per thousand live births. The reduction in the death rate for Mexican babies was conspicuous last year, however, as in 1937 there were 1,479 such deaths registered as compared with 1,131 in 1938, the rate falling from 121.5 to 87.6. Deaths in white babies dropped from 3,276 in 1937 to 3,056 in 1938, the rate falling from 42.2 to 36.4.

Among the counties with infant mortality rates lower than that for the state as a whole are the following: Alameda. Butte, Colusa, Contra Costa, Eldorado, Glenn, Humboldt, Inyo, Lake, Los Angeles, Marin, Napa, San Bernardino, San Francisco, San Mateo, Santa Cruz, Sierra, Siskiyou, Solano, Sonoma, Stanislaus, Tehama, and Yolo. Among the cities having infant mortality rates lower than that for the state as a whole are Alameda, Berkeley, Richmond, Martinez, Bakersfield, Los Angeles, Long Beach, Pasadena, Pomona, Santa Monica, Glendale, Redondo Beach, Whittier, San Rafael, Merced, Pacific Grove, Santa Ana, San Diego, San Francisco, Stockton, San Mateo, Santa Barbara, San Jose, Palo Alto, Santa Cruz, Watsonville, Vallejo, Petaluma, Santa Rosa, Modesto, Visalia, and Porterville.

Among the cities having the lowest infant mortality rates in 1938 are Berkeley, 17.2; Hayward, 16.7; Pasadena, 19.1; Pomona, 19.9; and San Mateo, 18.1. Infant mortality for the larger cities of the state in 1938 and 1937 are as follows:

	1938	*1937*
Oakland	45.6	45.1
Berkeley	17.2	19.4
Fresno	45.4	46.9
Bakersfield	38.0	69.0
Los Angeles	43.3	52.3
Long Beach	26.2	28.7
Pasadena	19.1	34.5
Glendale	20.8	29.5
Sacramento	44.6	47.1
San Diego	40.1	34.4
San Francisco	29.6	32.2
Stockton	42.9	40.2
Santa Barbara	43.6	59.6
San Jose	29.8	24.8

In consideration of the fact that, for biological reasons, a certain proportion of infant deaths cannot be prevented, it would seem that California's infant mortality rate is fast approaching a point of stabilization. Activities in local communities directed toward the health protection of mothers and children have increased greatly during the past year because of the provision of Social Security funds. Infant mortality, to a large extent, however, is affected by conditions that are not under human control, and the annual general trend of the rate is similar throughout most of the country. There is every indication, however, that present activities directed toward the saving of infant lives are productive of results. The infant mortality rate must be regarded as a sensitive index of the health, social and economic conditions that prevail among the communities of the state.

Infant Mortality 1938-1937—By Counties

	1938		*1937*	
	No.	*Rate*	*No.*	*Rate*
Totals	4,450	43.8	5,060	53.7
Alameda	281	39.1	281	40.5
Alpine	......	......	......	......
Amador	5	79.4	7	97.2
Butte	38	43.3	34	48.2
Calaveras	4	56.3	8	125.0
Colusa	7	38.9	9	55.2
Contra Costa	41	35.4	45	40.9
Del Norte	4	56.3	3	42.2
Eldorado	3	16.3	4	28.6
Fresno	219	66.9	264	91.3
Glenn	5	34.0	6	38.0
Humboldt	32	42.5	38	54.1
Imperial	161	104.1	190	132.2
Inyo	5	43.5	13	122.6
Kern	183	63.7	274	108.6
Kings	49	66.9	87	131.2
Lake	1	11.6	8	95.2
Lassen	17	53.4	14	44.0
Los Angeles	1,397	36.8	1,520	42.5
Madera	50	95.0	50	103.3
Marin	12	33.4	9	25.3
Mariposa	......	......	......	......
Mendocino	20	52.2	27	75.0
Merced	58	55.6	68	80.6
Modoc	15	119.0	4	43.9
Mono	1	111.1	......	......
Monterey	67	58.9	71	68.4
Napa	6	18.1	7	23.7
Nevada	15	45.7	8	28.0
Orange	129	60.4	136	66.3
Placer	14	46.3	19	64.2
Plumas	9	54.9	14	84.3
Riverside	119	60.1	145	81.9
Sacramento	122	44.7	118	46.6
San Benito	12	81.1	19	137.7
San Bernardino	147	50.6	187	70.2
San Diego	167	36.7	155	37.1
San Francisco	252	29.6	265	32.2
San Joaquin	100	49.3	137	73.9
San Luis Obispo	29	55.3	21	43.5
San Mateo	14	17.8	23	35.2
Santa Barbara	71	57.2	76	67.4
Santa Clara	115	45.6	159	66.7
Santa Cruz	21	34.4	34	58.7
Shasta	18	51.1	22	78.3
Sierra	1	40.1	......	......
Siskiyou	18	41.4	11	28.6
Solano	19	35.8	25	53.3
Sonoma	34	37.7	26	34.8
Stanislaus	47	35.3	68	53.3
Sutter	22	59.1	25	85.9
Tehama	6	23.1	7	26.2
Trinity	3	120.0	1	47.6
Tulare	128	56.5	168	89.9
Tuolumne	10	55.9	12	84.5
Ventura	100	73.5	103	87.9
Yolo	11	28.6	12	35.1
Yuba	16	66.1	23	93.5

Infant Mortality 1938-1937—By Race

	1938		*1937*	
	No.	*Rate*	*No.*	*Rate*
White	3,056	36.4	3,276	42.2
Negro	105	62.0	103	67.1
Indian	48	106.4	69	158.2
Chinese	15	27.5	23	42.4
Japanese	58	37.9	58	40.4
Mexican	1,131	87.6	1,479	121.5
Filipino	33	74.3	35	92.8
Others	4	21.7	17	80.2
Totals	4,450	......	5,060	53.7

ACTIVITIES OF AMERICAN FOUNDATIONS

Medicine and public health outrank education among the objects toward which American foundations now grant an annual total of $38,500,000, according to a survey of foundation-giving just completed by Raymond Rich Associates, consultants to foundations, learned societies and other nonprofit institutions. The survey, embracing reports from the 243 leading foundations, is an extensive revision of an investigation formerly published periodically by the Twentieth Century Fund.

In suggesting that the Rich Associates undertake this task, the Twentieth Century Fund placed at their disposal all records and materials used in previous reports, and assisted in preparation of the current issue, which considerably enlarges the scope of previous studies. The Associates, however, bear all responsibility for the new report.

The survey indicates that for medical research, medical education, the erection and support of hospitals, and other purposes related to medicine and public health, foundations granted individuals and institutions more than one-third of their total disbursements, or $13,495,898 during 1937 (the latest year for which complete figures are available).

Education, for many years the foremost concern of foundations, dropped to second place and received but one-fourth, or $9,170,318, of the total gifts. The other leading fields in which foundations subsidize projects are, in the order of their importance from the standpoint of grants: social welfare, $4,695,880; physical and biological sciences, $2,253,298; government and public administration, $1,710,598; economics, $1,353,386.

In bringing together these and other figures covering foundation activities and structures, the Rich organization restricted its report to foundations that paid out at least $1,500 during 1937 for projects not directly controlled by foundation staff members. The Twentieth Century Fund's former surveys provide comparable figures for 1934 and 1931.

Several large foundations gave the bulk of foundation subsidies for medical and public health projects. The General Education Board, a Rockefeller fund, allotted $5,120,446 to this field in 1937, The Rockefeller Foundation $4,222,472, and The Commonwealth Fund $1,367,644. During the past five years, the report states, The Commonwealth Fund—a Harkness benefaction—has devoted an increasingly larger share of its annual payments of $1,750,000 to $2,000,000, to medical research.

Gifts of the Carnegie Corporation of New York for medicine and public health amounted to $525,250 in 1937. The John and Mary R. Markle Foundation since 1935 has limited its new activities to research in the medical sciences and spent $224,550 on such projects in 1937. Public health and medicine are also the chief interests of the Milbank Memorial Fund and the Josiah Macy, Jr., Foundation, to the extent of $165,328 and $183,314 a year, respectively.

An intensified interest in medicine and public health is further evidenced by the establishment of new foundations created specifically to lend assistance in this field. The Rich report lists the following large medical foundations set up in the last five years: The Jane Coffin Childs Memorial Fund for Medical Research, which subsidizes cancer investigations, established in 1937; Dazian Foundation for Medical Research, 1938; The Samuel S. Fels Fund, 1936, interested primarily in discovering ways to maintain health; Finney-Howell Research Foundation, Inc., 1937, established to promote the study of cancer; The National Foundation for Infantile Paralysis, 1938; The Nemours Foundation, 1936, whose current project is the erection of a hospital for crippled children in Delaware; and Zachary Smith Reynolds Foundation, Inc., 1936, which is financing a campaign to control venereal diseases in North Carolina. In addition, the control and elimination of disease is one of the purposes for which the Rosenberg Foundation was set up in 1937 in California, and it gave a large share of its $56,500 disbursements during its first year of operation for medical research.

Projects in the educational field received about one-fourth—$9,170,318—of the grants paid in 1937, while social welfare accounted for approximately one-eighth—$4,695,880—of the total. In the education field, the General Education Board once again led with grants of $3,794,192 in 1937, and the Carnegie Corporation of New York contributed $1,850,285. The third largest source for foundation funds in support of educational projects was the Horace H. Rackham and Mary A. Rackham Fund, which granted $1,101,000 in 1937.

The three largest donors to social welfare projects in the year under survey were: The Carnegie Foundation for the Advancement of Teaching, $1,922,835; the Rackham Fund, $496,850; and the New York Foundation, $407,841. Grants in the field of social welfare, including direct relief to individuals, have been decreasing since 1931.

The physical and biological sciences received the fourth largest share of the grants, a total of $2,253,298. The leading donors of these funds were: The Rockefeller Foundation, with gifts of $1,094,052 in 1937; General Education Board, $791,638; and the Carnegie Institution of Washington, $76,564.

Grants for projects in the field of government and public administration totaled $1,710,598 in 1937 and were given chiefly by two Rockefeller foundations. The Spelman Fund of New York contributed $1,076,420, and The Rockefeller Foundation distributed $588,450.

An increasing proportion of foundation income is being allotted to individuals and organizations working on economic problems. Such grants, however, still rank sixth in the list of totals, aggregating $1,353,386. The Rockefeller Foundation gave $1,136,475 of this, chiefly for research in social security problems. Two other large foundations are now concentrating their funds upon economic projects; these are The Maurice and Laura Falk Foundation of Pittsburgh, formed in 1929, and Alfred P. Sloan Foundation, Inc., of New York, organized in 1936.

The social sciences other than economics did not share the increased interest in economic problems, the Rich organization discovered. Sixty foundations, whose grants for 1937, 1934, and 1931 may be compared, expended $882,920 on social science in 1937, 71 per cent less than 1934 and 84 per cent under 1931.

Thirty-nine of the 243 foundations each made total grants of $100,000 and more in 1937. Of these, the General Education Board led the list with disbursements of $9,716,277, a figure due in part to the policy of liquidation adopted by the organization's directors. The Rockefeller Foundation ranked second with $8,996,016, and the Carnegie Corporation of New York third with $3,695,534.

Thirty-one of the foundations making the largest grants had also reported their grants in 1934 and 1931. Of these, twenty-two made more sizeable disbursements in 1937 than in 1934. The Wieboldt Foundation increased its payments by 265 per cent, rising from $30,300 to $110,650. Grants of the Lucius N. Littauer Foundation increased 225 per cent, from $32,557 to $105,901. The Horace H. Rackham and Mary A. Rackham Fund, established in 1934, made disbursements of $2,164,950 in 1937, four times as much as its payments of $527,110 in 1934.

Other large increases in total gifts were those of the W. K. Kellogg Foundation, whose 1937 grants of $572,685 were 127 per cent greater than its 1934 total, and the Josiah Macy, Jr., Foundation whose increase was 95 per cent to $211,239 in 1937. The grants paid by the General Education Board, the Chicago Community Trust, and the John Simon Guggenheim Memorial Foundation, all were more than 74 per cent greater in 1937 than in 1934.

TWENTY-FIVE YEARS AGO[†]

EXCERPTS FROM OUR STATE MEDICAL JOURNAL

Vol. XII, No. 6, June, 1914

From Some Editorial Notes:

Proceedings of the Council.—During the time of the annual meeting at Santa Barbara, the Council held four meetings, the 72nd, 73rd, 74th, and 75th. . . .

Modoc and Lassen-Plumas County Medical Societies, which had been organized in March, were officially accepted in affiliation with the State Society. . . .

* * *

County Societies: Important.—A number of matters directly affecting county societies and membership in them and in the State Society, the privileges of medical defense, etc., were acted upon by the House of Delegates and referred to the county units for action. Each county unit should take these up as soon as possible and act upon them. The only legislation by the House of Delegates which was not unanimous was the endorsement of the proposed agreement in regard to the work under the industrial accident law; there were about ten opposing votes on this measure, but it was adopted and referred to the county units for their ratification. Four county societies have already, at the time of writing, met and rescinded resolutions previously passed, and have endorsed the action of the House of Delegates. All county units should act upon these various matters (they will be found in the Minutes of the House of Delegates, published in this issue of the Journal) as soon as possible, that there may be no delay in knowing just where we stand on all of these points. More than ever is it clear that the House of Delegates' plan is a good one; a body of from 90 to 100 men, representing the whole state, can transact the business of the Society more satisfactorily than could the whole mass of the Society. A surprisingly large amount of work was done in a short time and without hitch or friction of any sort.

* * *

Surgeon-General's Library.—At the Santa Barbara meeting a protest was read, calling attention to an amendment to the Army appropriation bill, which amendment would take the library of the Surgeon-General away from its present quarters and combine it with the Congressional Library and would have almost put a stop to the wonderfully good work that is being done by the machinery provided in the Surgeon-General's Library. The Secretary was instructed to take up this matter by telegram with our representatives in Washington, and it is with pleasure that the information contained in the following telegram is now placed before our readers:

"Washington, D. C., May 5, 1914.

"Army bill now law. Senate amendment defeated. Medical library continues its former status.

"(Signed) Julius Kahn."

* * *

Scientific Work.—It is gratifying to note the steady improvement in the quality of the papers presented at the annual meetings of the Society. At the Santa Barbara meeting of this year, the general average of the papers was very high and the range of subjects presented made an exceedingly attractive and interesting program. The tuberculosis society is to be congratulated upon the activity

(Continued in Front Advertising Section, Page 15)

BOARD OF MEDICAL EXAMINERS OF THE STATE OF CALIFORNIA[†]

By Charles B. Pinkham, M. D.
Secretary-Treasurer

News

"Preliminary hearing into the case involving Dr. John M. Robinson, 37-year-old physician-socialite, charged with criminal abortion, will be heard today (Thursday) in Division 4 of the Municipal Court. Doctor Robinson was arrested last week in connection with the death of Mrs. Gladys Smith, 19-year-old former acrobatic dancer. Mrs. Smith died on April 19 at the General Hospital, allegedly from an illegal operation performed on her by Doctor Robinson." (Los Angeles *Eagle,* May 4, 1939.)

"Dr. Charles H. Wilson, chiropractor of 217 North Vermont Avenue, accused of causing the death of Mrs. Ursula Warner, 33-year-old Hermosa Beach housewife, by an illegal operation, was up before Municipal Judge C. A. Ballreich today on charges of murder and performing an illegal operation. The woman's husband, William F. Warner, testified that he took his wife to Doctor Wilson's office on April 21 and that she was closeted with the doctor for nearly an hour. When they returned home, he said, she became violently ill and was later removed to the Torrance Hospital. She died there three days later, he testified, despite the effort of five doctors called into consultation. . . ." (Los Angeles *Herald and Express,* May 9, 1939.

"Convicted late last night of a charge of performing an unlawful operation, Dr. O. A. Welsh, 50-year-old Ventura surgeon, today is at liberty under $2,500 bond, pending pronouncement of sentence on Tuesday. The jury returned its verdict at approximately 11:25 p. m., finding the doctor guilty of the operation charge, but acquitting him of a morals count. Doctor Welsh was indicted by the Ventura County Grand Jury on January 23. . . . The case closed with a flourish yesterday morning when the District Attorney called to the stand two young Santa Barbara mothers, both of whom testified their husbands had paid Doctor Welsh $50 to perform operations to prevent them from having additional children. . . . Doctor Welsh, former World War army surgeon, has practiced in Ventura for the past nine years." (Ventura *Star-Free Press,* May 5, 1939.)

"The Municipal Retirement Board yesterday rejected a plan for drugless practitioners to participate in the city workers health service system. Members of the profession had objected to details of the plan and its adoption by directors of the health service system and taken their case to court. . . ." (San Francisco *Examiner,* May 10, 1939.)

"Doctor Frederick Waitzfield (Waitzfelder) physician and surgeon, 3950 West Sixth Street, yesterday was granted one year probation on two counts of violation of the state narcotics act by Municipal Judge Harold B. Landreth, who suspended a sentence of 180 days on each count. Judge Landreth made a provision of the probation that the physician refrain from administering or prescribing narcotics during his probation. The court pointed out Doctor Waitzfield (Waitzfelder) had technically violated the act

(Continued in Front Advertising Section, Page 24)

[†] This column strives to mirror the work and aims of colleagues who bore the brunt of Association activities some twenty-five years ago. It is hoped that such presentation will be of interest to both old and new members.

[†] The office addresses of the California State Board of Medical Examiners are printed in the roster on advertising page 6.

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Refugee Physician Immigration Figures Since 1930 Compiled.—Government figures on the refugee physician problem in the United States are given by *The Journal of the American Medical Association* for February 25. The report says:

"According to material obtained through Government agencies, alien immigrants describing themselves as physicians have entered the United States during each fiscal year since June 30, 1930, as shown in Table 1.

Table 1.—*Annual Immigration of Alien Physicians*

Fiscal Year Ended June 30	From All Countries	From Germany-Austria	Physicians Listed as Jewish
1931	329	16	38
1932	259	23	34
1933	187	8	41
1934	353	166	163
1935	304	104	137
1936	462	253	273
1937	533	286	310
1938	738	365	475

During the four months July, August, September and October, 1938, 482 alien immigrants who described themselves as physicians entered the United States. Of these 390 were Jewish physicians.

"Neither the foregoing figures nor those that follow include alien physicians who entered the United States as tourists and whose stay is accordingly limited. No evidence has been found to show that any order has been issued undertaking to extend the time during which such alien tourist physicians may remain in this country. No evidence has been found to show that alien physicians find their way into the United States for permanent residence by entering through countries other than those in which they respectively are nationals; as, for instance, German physicians entering the United States by way of, say, some country in South America.

"As between the fiscal year ended June 30, 1937, and the fiscal year ended June 30, 1938, the outstanding changes in the numbers of immigrant physicians entering the United States are shown in Table 2.

Table 2.—*Increase in Immigration Within Two Years*

From	Fiscal Year Ended June 30, 1937	Fiscal Year Ended June 30, 1938
Germany-Austria	286	365
Italy	14	26
Switzerland	11	25
Canada	79	107

Table 3.—*Racial Stocks Represented*

	Fiscal Year Ended June 30, 1937	Fiscal Year Ended June 30, 1938	Four Months July-October 1938
English	31	36	11
German	98	86	43
Jewish	310	475	390
Irish	11	18	1
Magyar	7	12	6
Scotch	10	26	10

"Immigrant physicians from Asia increased from thirteen in 1937 to thirty-three in 1938, the number arriving in the latter year coming from China, ten; India, one; Palestine, twenty; and Syria, two. It does not necessarily follow, however, that physicians arriving from those countries were not Caucasians."

(Continued on Page 36)

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(Continued from Page 34)

After reëmphasizing such limiting factors of the problem as immigration quota restrictions, *The Journal*, editorially, says:

"Unfortunately, there are publications, political groups, and subsidized agencies in this country which are endeavoring to make prestige and favor for themselves by stirring the motives of selfishness, prejudice, and hatred among American doctors. In *The Journal*, February 11, six distinguished leaders of America medicine urged the medical profession to coöperate with the special committees that have been set up in New York and Boston for helping in this situation. The committees specifically concerned with the problem of the refugee who is a physician are:

"Emergency Committee in Aid of Displaced Foreign Physicians, 59 East Fifty-Seventh Street, New York, Dr. Emanuel Libman, chairman, Dr. Laurence Farmer, executive secretary. This nonsectarian committee deals with a select and small number of prominent scientists, for whom positions are found in the field of medicine for research and study.

"National Coördinating Committee for Aid to Refugees and Emigrants Coming from Germany, 165 West Forty-Sixth Street, New York, Joseph P. Chamberlain, chairman, Miss Cecilia Razovsky, executive director. This committee coördinates the activities of the major organizations working in this field.

"Boston Committee on Medical Emigrés, 114 Riverway, Boston, Dr. David L. Edsall, chairman (The Problem of the Refugee Physician, *The Journal*, February 11, p. 570).

"Various suggestions have come to the American Medical Association urging the establishment of a special committee to handle this problem. Thus far the only action taken by the House of Delegates has been a recommendation to the state boards of medical registration that citizenship be requirement for license to practice. As every physician knows, the right to regulate the practice of medicine rests with the individual states. As the letter recently published points out in the field of general practice and in the specialties also numerous openings exist for which it is difficult to find qualified American physicians; for example, poorly paid full-time positions and practices in rural communities.' If any of the committees concerned can undertake to make a survey to locate such openings, a certain number of the refugees can be absorbed with a minimum amount of disturbance of the rights of American physicians.

"The chief difficulties that have arisen in this situation arise from the fact that some of the refugees are poorly trained or of low ethical standing, that some find it difficult to adapt themselves to American ways in the practice of medicine, and that many tend to settle in large cities already overcrowded with physicians. Certainly, a physician who is poorly trained or of low ethical standing should not be permitted to practice anywhere. Perhaps the difficulties of adaptation can be overcome by well-planned instruction. Only the coördinating committees already mentioned, or groups of a similar character, can aid in solving properly the problem of suitable distribution of the refugees to places where they may be useful rather than a foreign body setting up irritation and forcing extrusion."

Only 6 Per Cent.—Of 8,654 veterans of the World War hospitalized for tuberculosis in six months, 71 per cent were far advanced, 23 per cent moderately advanced and only 6 per cent were minimal.—Matson, R. C., U. S. Vet. Ad. Phys. Conf., 1938.

Man has subjected animals to his use; but he has also subjected himself to many of their diseases.—*Hygeia.*

A MESSAGE TO HOME CANNERS FROM THE CANNING INDUSTRY

● Every year, in various regions of the country, a considerable amount of the produce from thousands of small orchards and gardens is preserved for future use by canning in the home. Despite much that has been written on the subject (1), outbreaks of botulism from improperly heat processed home-canned foods continue to be reported.

To eliminate the possibility of botulism from their products—specifically those foods of the "non-acid" type—home canners should take a page from the experience of commercial canners. Through considerable research, the American canning industry has scientifically established the necessary processing requirements for products of this character. For non-acid foods, modern canners employ only recommended process time and temperature schedules(2) known to be adequate to destroy the heat-resistant spores of clostridium botulinum whose growth produces the toxin which causes the deadly type of food intoxication known as botulism.

Brief comment on the heat-processing requirements of common foods might be in order. In general, foods or food products may be classed into two groups according to their acidity, i.e., the "acid" and "non-acid" classes with pH values below and above 4.5, respectively. The acid foods include tomatoes and the common fruits. These foods are not favorable to the growth of clostridium botulinum and consequently they may be safely processed at 212°F., or the temperature of boiling water.

The non-acid products, however, present a special processing problem. Such products—meat, fish, fowl, milk and most common vegetables—can be adequately processed only at temperatures above 212°F. As the records indicate (1) botulism in home canned foods may result from processing non-acid foods in boiling water. Safe canning of these foods in the home, therefore, requires the use of properly operated "pressure cookers"—identical in principle with the "retorts" used by commercial canners—which will permit the use of a process under steam pressure. Usually 10 lbs. steam pressure is used in these cookers which corresponds to a processing temperature of 240°F.

Home canners desiring to pack non-acid products should obtain a copy of United States Department of Agriculture Farmers Bulletin No. 1762. In this bulletin are described the necessary equipment, precautions, and time and temperature processing schedules required for the safe canning of non-acid foods in the home. If the necessary equipment cannot be obtained and the recommendations contained in the above bulletin cannot be faithfully followed, some means of preservation of non-acid products other than canning should be sought.

In the interests of public health, it is our sincere hope that home canners may soon become educated to the necessity of steam pressure processes for non-acid foods. Experience dictates that only by processes of this type, with a time and temperature schedule suitable for each particular product, can botulism from non-acid home canned foods be effectively controlled and ultimately eradicated.

AMERICAN CAN COMPANY

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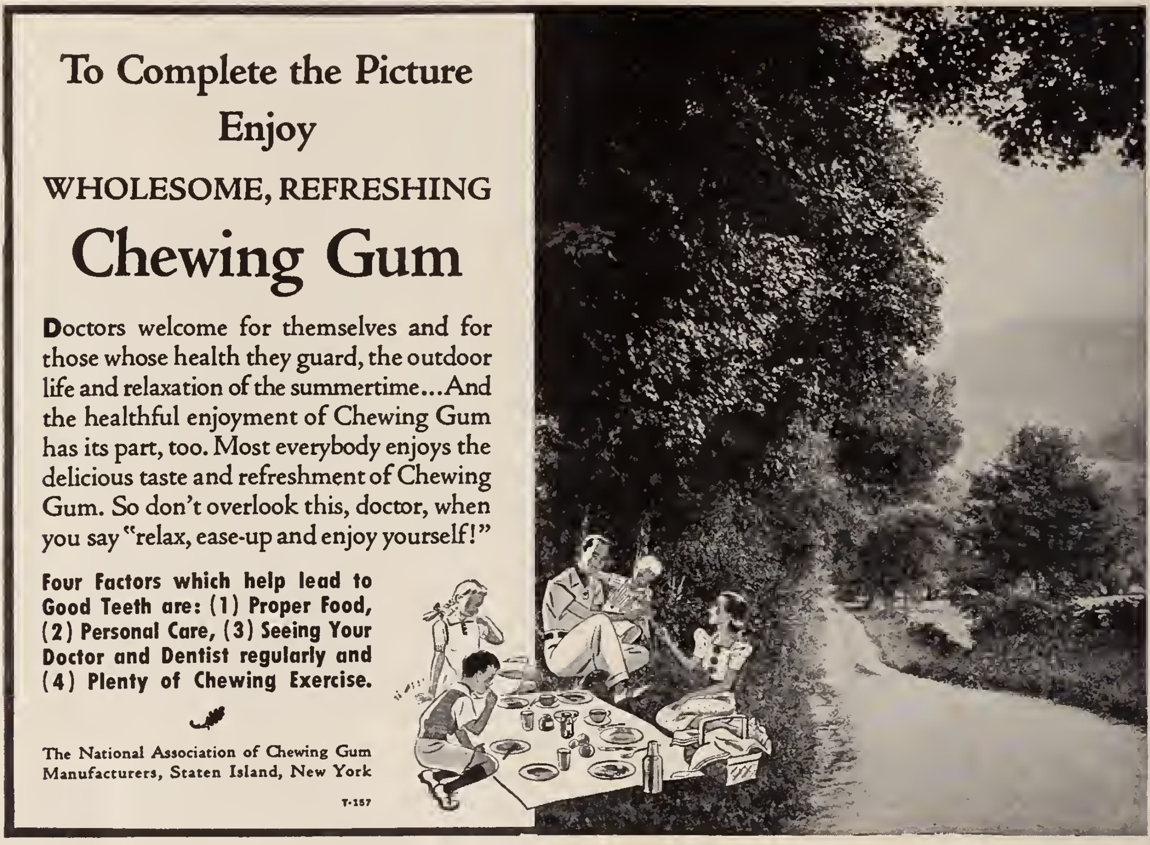
1. 1934. J. Home Econ. 26, 365-376.
   1935. Amer. J. Pub. 25, 301-313.
   1935. J. Amer. Med. Assn. 105, 205.
   1936. Food Research 1, 171-198.
2. 1937. National Canners Association, Washington, D. C. Bulletin 26-L, 3rd Ed.

We want to make this series valuable to you, so we ask your help. Will you tell us on a post card addressed to the American Can Company, New York, N. Y., what phases of canned foods knowledge are of greatest interest to you? Your suggestions will determine the subject matter of future articles. This is the forty-eighth in a series, which summarize, for your convenience, the conclusions about canned foods reached by authorities in nutritional research.

The Seal of Acceptance denotes that the statements in this advertisement are acceptable to the Council on Foods of the American Medical Association.



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Blindness.—There are at least 117,000 totally blind persons in the United States, according to estimates of the National Health Survey by the United States Public Health Service.

In presenting this figure, George St. John Perrott, director of the Survey, stated that blindness, which already constitutes a major problem in society, will be likely to increase because older persons, among whom blindness is more prevalent, are constituting a larger and larger proportion of the population. One-fourth of the blind are over 75 years of age and three-fifths are over 55.

Cataract, glaucome, trachoma, optic nerve atrophy and other eye diseases coupled with more general diseases such as high blood pressure, hardening of the arteries and diabetes are responsible for nearly three-fourths of all blindness. The rest is attributed to accidents (about 21 per cent) and congenital or early infancy causes (approximately 7 per cent).

Among the accidents causing blindness—which account for about one-fifth of the entire amount—the largest single cause is falls (16 per cent); next in order come automobile accidents and burns (each 10 per cent); and poisonings and firearms (each 7 per cent); the remaining 50 per cent is distributed over a large number of known and unknown types of accidents. Forty-three per cent of these accidents are classified as occupational injuries, those occurring at work; 27 per cent occurred in the home and 30 per cent in public places, including automobile accidents.

The report pointed out that blind persons are concentrated in the low income groups. Seventy per cent were found to be in families with annual incomes of less than $1,000.

The prevalence of blindness among men is greater than among women, according to Survey findings. For every 100 blind women there are 111 men afflicted with blindness. Among youths (15-24 years), the prevalence rate for males is 20 per 100,000, while the female rate is only 9 per 100,000. Figures for the younger working ages (25-44) show a prevalence of 144 blind per 100,000 men, while the rate for women is only 28. In the oldest age grouping (65 and over), however, the rate is 706 per 100,000 women to 660 per 100,000 men.

The Survey found nearly twice as much blindness among colored people as among whites in proportion to their numbers. The rate of blindness for colored persons is 146 per 100,000 as contrasted with 75 for the white population.

Only 11 per cent of the blind were reported as being employed in gainful occupations, leaving the greater number dependent upon private or public support.

This study of the National Health Survey was primarily concerned with total blindness, which included "all persons reported by the family as being blind in both eyes." In connection with the study, however, figures for blindness in only one eye were compiled and it was estimated that "in the general population there were about 425,000 persons blind in one eye only," as against 117,000 persons blind in both eyes.

Three Hundred X-Ray Examinations per Hour.—A new method of x-raying the chests of large groups cheaply and quickly has been developed in Germany. It consists of photographing the fluoroscopic image on motion picture film. When developed, the strip of film is projected on a screen for interpretation. By this method two physicians, assisted by a crew of ten men, examined at the rate of three hundred per hour, more than 10,000 men during a Nazi party celebration at Nüremberg. The device is not a substitute for the standard x-ray technique but is a means of "screening" and it promises the possibility of examining the whole nation.—Holfelder, H., and Berner, F., Muenchen, Med. Wchnschr., 1938, 47.

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Lederle at the New York World's Fair.—In the Medicine and Public Health Building, New York World's Fair, Lederle Laboratories are sponsoring the scientific exhibits on Allergy and on Pneumonia, each exhibit being controlled by a committee of eminent specialists on these diseases. All exhibits in the building are scientific in character, merely carrying on a small plaque the names of the sponsors.

The Pneumonia exhibit, surfaced entirely of white laminated "Beetle," occupies a booth 20 x 30 feet in a commanding position. It presents, pictorially, the best composite opinion of the medical profession on how a pneumonia case should be treated. The narrative is unfolded by means of a sequence of dioramas, pictures, and charts. The story begins with an "animation" of a man walking in the rain, and takes him through typing and serum therapy and all the various progressive stages of a typical case of pneumonia to a final picture at the serum farm where his little daughter is pictured, saying, "Thanks, old horse, you saved my Daddy's life!" A "postscript" deals with sulfapyridine.

The second exhibit, on Allergy, tells, in changing dramatic sequences, three two-minute dramas of Allergy: "Tommy Todd's Autumn 'Colds,'" "Mrs. Tucker's Wheezes," and "Baby Bing's Eczema."

By means of an animated question box and dioramas showing typical scenes in the doctor's office, a search for the offending allergic excitant in each of the three stories is conducted through information obtained by questions, scratch tests, and an examination of the patient's family tree. An interesting part of the allergy exhibit is an illuminated transparency chart showing in full color, forty-eight of the most common allergic excitants. A separate series

(Continued on Next Page)

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(Continued from Preceding Page)

of little pictures invites the visitor to examine commonplace scenes for causes of allergy and then, by pressing buttons, to illuminate the concealed answers.

Both exhibits are addressed to intelligent laity, and are attracting close attention.

Physicians visiting the New York World's Fair are entitled to exclusive privileges in the Professional Club in the same building. Admission is obtained by simple identification as a doctor, without charge, and is only available to physicians and their guests. Provision is made here for consultation with exhibit sponsors on technical questions.

Flexibility Needed in Legislation on Syphilis Control. Extreme care must be exercised in the enactment of venereal disease control legislation, especially that involving syphilis, if much harm to future health regulation measures is to be avoided, John H. Stokes, M. D., and Norman R. Ingraham, Jr., M. D., Philadelphia, warn in *The Journal of the American Medical Association* for March 25.

The two authors, in their paper, "Syphilis and the Law," point out that much of the existing health legislation on syphilis is not based on sound legal or medical principles. They state that, fundamentally, health regulations involving questions of infectious stages of syphilis must be broad and flexible in their scope. They take a stand in opposition to any attempt by law to define infectiousness or noninfectiousness too rigidly, and recommend that special legislation for the control of venereal disease should not depend solely on laboratory tests but should provide for expert medical judgment to insure necessary latitude in interpretation.

"All law, and public health law in particular, should be an expression of educated public demand and should arise not from waves of fear, sentiment, hysteria or propagandist activity, but from the broad base of intelligent comprehension of the problem involved," the two physicians declare.

"In the case of syphilis there exists a sufficient body of expert knowledge as to what constitutes public health protection and a sufficient unanimity of opinion on treatment control to make the framing of sound legislation a practicality.

"It would seem, first of all, that laws regulating the control of syphilis should take account of the enormous variability in individual cases and the positive necessity for expert medical interpretation whenever a serious question arises.

"Laws governing syphilis will tend to be too specific and drawn in too great detail. So far as they preserve the right of the state to allow its public health officers to decide by individual local or official regulation in a flexible manner the processes of enforcement and judgment, subject to cooperative interpretation by the court, they are likely to be good.

"So far as the enactments tend to define in days and weeks and to specify in degrees of positiveness and negativeness of specific tests, they will tend to run into difficulties both in the infliction of injustice on individuals and in unenforceability in the light of expert testimony in the courts.

"The medical principles with respect to syphilis which all law enforcement must recognize are essentially these:

"First, no single test or single procedure uncontrolled or unchecked should be conclusively diagnostic of syphilis. Serologic syphilis and clinical syphilis from the standpoint of public health are by no means identically significant. There exists a serologic syphilis which has virtually no public health significance, and there exists a clinical syphilis without serologic confirmation which is of the highest

(Continued on Page 42)

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Lederle's exhibit on "Allergy" at the New York World's Fair (Medicine and Public Health Building) presents in silent pictured narrative an ingenious popular review of the subject.

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(Continued from Page 40)

importance from the standpoint of the transmission of the disease.

"Law and regulatory practice in the control of syphilis which makes the result of the blood test the arbiter of decisions involving the civil rights and individual freedom of persons cannot stand critical review in the courts of a liberty-loving and intelligently guided people.

"The congenital syphilitic man or woman, particularly, who has reached adult life with an irreversibly positive blood reaction for syphilis can suffer all the penalties of the law with little or no justification. The patient with a primary lesion still in the seronegative stage or an infection reduced to temporary invisibility and serologic negativity by inadequate treatment can be a public danger of the first magnitude and yet remain entirely outside the control of a law so drafted.

"A second principle based on the characteristics of syphilis as a disease and one which when confronted in its full meaning is extremely embarrassing to venereal disease control officers is the definition of infectiousness and noninfectiousness. No absolute definition of noninfectiousness and no means of infallibly attaining it exists at the present day.

"There will always be in practice patients who have had sufficient treatment to exceed a reasonable standard of control of infectiousness, who are still periodically relapsing and periodically infectious.

"It is, therefore, one of the first duties in research on syphilis to attempt to define broad categories of infectiousness and noninfectiousness. Special legislation for the control of venereal disease should not be written to depend purely and simply on laboratory tests. The factor of expert medical judgment must be drawn into the phraseology in a way to provide for a necessary latitude in interpretation, yet without permitting escape of the individual through a loophole of professional ignorance or connivance.

"Until legal enactment becomes general throughout the country, evasion must inevitably be expected. Since it is extremely difficult to define the amount of treatment which cures syphilis, and impossible at this writing to define exactly what cure is, marriage legislation should limit itself to the use of the term 'noninfectiousness' if it proposes to withhold license to marry as long as a person can be regarded as capable of transmitting the disease.

"The ultimate question as to whether the state can on any serologic grounds at least, and perhaps even on any combination of clinical and serologic grounds, definitely and finally or even indefinitely withhold permission to marry must ultimately be decided by the courts. As syphilologists we must take a definite stand against the validity of purely serologic criteria in decisions of this sort. If the law is pushed to this extreme at any point, public health policy with reference to the control of infectious disease will have a critical review such as it has never sustained in all its past.

"In matters involving the job, current practice quite largely fails to discriminate between infectious or disabling syphilis and harmless syphilis. There is evidence of grapevine telegraphy, action without authority, disregard of medical knowledge and supervision, misapplication of medical treatment principles by laymen in supervisory capacities and use of results of blood tests as pretexts for personal and unfair discriminations."

Motility of Spermatozoa Does Not Always Indicate Fertility.—Motility of spermatozoa, contrary to prevalent belief, does not necessarily indicate fertility, Frances I. Seymour, M. D., New York, reports in *The Journal of the American Medical Association* for May 6.

In her report on the case of a problem of sterility of an Eastern college professor and his wife, Doctor Seymour points out that although the sperms of the professor were motile, artificial insemination tests with sixteen volunteer women and his wife proved them to be sterile.

Additional confirmation of the sterility was obtained by artificial insemination of the seventeen women with the sperm of another man, an eminent figure in his profession, whose fertility index was known. Pregnancy resulted in all of the women.

In the same issue, *The Journal* discusses the legal phases of artificial insemination. The editorial says:

"Whether a child begotten from artificial insemination is legitimate or illegitimate according to the law is an important question. If the child is illegitimate and if the

(Continued on Page 44)

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husband of its mother fails to adopt it legally, the child does not acquire rights to inherit from the husband. A child is legitimate if its parents are intermarried when it is begotten or born. Statutes generally legitimatize also the issue of illicit intercourse if the parents intermarry, even though the intermarriage occurs after birth. The fact that conception is effected not by adultery or fornication but by a method not involving sexual intercourse does not in principle seem to alter the concept of legitimacy. This concept seems to demand that the child be the actual offspring of the husband of the mother of the child.

"The presumption of law that a child born during wedlock is legitimate is not absolute and conclusive under all circumstances. Even at early common law the presumption was overcome by proof of the husband's sterility. Today the presumption as to legitimacy is more easily controverted than it was in earlier times. Now it is generally recognized by the courts that a child is illegitimate, though born or begotten during marriage, when it is impossible that its mother's husband could have been its father. Every species of legal evidence tending to this conclusion is admissible on the trial of the issue as to its legitimacy.

"Artificial insemination can be effected from only two sources: from the semen of the husband of the prospective mother and from the semen of some other male. If the semen of the husband is used, the child obviously is as legitimate as if it were the result of normal and usual intercourse between husband and wife. If the semen of some other male is utilized, the resulting child would seem to be illegitimate. The fact that the husband has freely consented to the artificial insemination does not have a bearing on the question of the child's legitimacy. If it did, by similar reasoning it might be urged that the fact that a husband had consented to the commission of adultery by his wife would legitimatize the issue resulting from the adulterous connection.

"Some advise that all question as to the legitimacy of a child produced from the semen of a male other than the husband of the mother be ignored, apparently relying on the secrecy attendant on artificial insemination and on the presumption of law that a child born during wedlock is legitimate. Such reliance, however, disregards the apparent intent of the husband to confer on the child the rights incident to legitimacy. Those rights, if illegitimacy or even doubt as to legitimacy is frankly recognized, can be assured by adoption proceedings, which ordinarily are comparatively simple.

"In many instances of artificial insemination, perhaps in a great majority, the facts may never be known to any one other than husband and wife and the physician involved. There is the possibility, however, that interested relatives may learn of the circumstances and may procure the evidence necessary to overcome the presumption of legitimacy and may thus deprive the child of a share of intestate property. It is the just due of the child that false pride or considerations of delicacy be put aside and that it be given, through adoption proceedings, the protection intended by the husband of the mother when he consents to the artificial insemination of his wife."

Deaths From Appendicitis Increased During Depression Years.—Delayed operation, attributed largely to economic factors and use of home remedies, including laxatives, was responsible for an increased death rate (9 to 23 per cent) in the acute suppurative (pus-discharging) type of appendicitis among 1,000 adult cases of all types between 1931 and 1936 in Cleveland, as compared with the same number during the previous five years, F. R. Kelly, M. D., and R. M. Watkins, M. D., Cleve-

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land, report in *The Journal of the American Medical Association* for May 6.

The significance of the depression years in the increased mortality rate, they point out, is emphasized by the findings of other investigators who have reported a similar increase. Their report, as was the first one in 1931, is a review of consecutive cases. With the exception of the sharp increase in mortality, they found no great variations between the two series of reviews.

In a few cases of suppurative appendicitis the operation should be deferred. In the greater number, however, surgical measures should be taken at once.

"The increase in mortality," they say, "can be explained in three words: delay in operation. We have in mind three causes for this delay:

"(*a*) Changed economic conditions. The first thousand cases occurred from about 1925 to 1930, when the nation was in a prosperous state economically. The second series of 1,000 occurred from 1931 to 1936, when conditions were entirely different. The records show that in the early series the patients were ill for 3.8 days before operation and in the later series for 4.9 days. This means that during these depression years patients delayed operation 29 per cent longer than in better times. This surely increased the mortality rate.

"(*b*) Home treatment, especially with laxatives. This subject may be a corollary of the previous one, because the increase of the use of home measures probably is a mirror of the economic state. During the delay in reaching surgical aid the patient is using various medicines suggested by those about him, and among them, unfortunately,

(Continued on Next Page)

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are laxatives. We have gleaned from the records the facts that in the 1925-1930 series, 42 per cent reported having done so. We feel that the increase of laxative taking has been partly responsible for the increase in mortality. Of the patients who died of what we term immediate causes, twenty-one, or 67 per cent, reported taking laxatives. Complicating factors in diagnosis were also found to cause delay in operation."

Doctors Kelly and Watkins pay credit to J. O. Bower, M. D., Philadelphia, for actively campaigning for education of the public regarding the dangers of laxatives in such cases. He found that of 306 patients who died of acute suppurative appendicitis, 147, nearly half, had taken laxatives. In another series he reported that 91.6 per cent of 214 patients who died of acute diffuse peritonitis following appendicitis had taken them.

The importance of early operations in cases of acute suppurative appendicitis is stressed by the authors in their report that 28 of their 190 patients in the second series were operated on less than twenty-four hours after rupture, with a death rate of only 3.5 per cent, whereas of 86 who were operated on forty-eight or more hours after rupture, 32 per cent died.

Education of the public to the importance of seeking early medical attention for abdominal pain will decrease this mortality rate, the authors say, pointing out that "if economic conditions improve, this delay on the patient's part will be lessened, but in the meantime persons should be told to pocket their pride and seek medical aid, regardless of their circumstances, if they have pain in the abdomen. For this educational measure the great publicity mediums of newspapers, magazines, radios, public speeches and placards can well be used, as they are being employed now in the campaigns against cancer and syphilis. Especial attention must be placed on the danger of taking purgatives in the presence of abdominal pain."

Describes New Wrist Fracture Splint.—A splint for Colles fracture (of the wrist) which permits normal use of the hand in such operations as writing and eating is recommended by Frederick H. Amendola, M. D., New York, in *The Journal of the American Medical Association* for May 6.

While union of the wrist bone requires uninterrupted fixation of the fragments, a better recovery will be obtained if the splint allows complete function of every muscle and joint which does not have to be kept motionless, Doctor Amendola declares.

Describing his procedure, the author says, "If x-rays show a satisfactory reduction, plaster splints (front and back) are applied. Both splints are lined with a thin layer

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of cotton padding and they are securely fixed with gauze bandage.

"The patient is instructed to start immediate active motion of the fingers. He is permitted to discard the sling at home for several hours at a time to permit elevation of the arm and flexion and extension of the elbow.

"These splints are not disturbed for about five days. By that time most of the swelling will have disappeared and the splints will be ready for final adjustment. Without disturbing the splints, some of the outer gauze bandage is removed. A very light circular bandage of plaster is then applied over the splints and gauze. This circular bandage must be snug enough to prevent any movement at the wrist and it must be applied so that it does not interfere with complete motion of the fingers and thumb.

"The patient should be able to clench the fist completely and to pick up and use a pencil or a fork without difficulty. The splint should be light enough so that the sling may be discarded completely after a few days.

"There is seldom any need for further adjustment of the splints, and they are worn until the fracture is solidly healed and all danger of displacement has passed (that is, for from three to six weeks). When the splints are discarded the patient is instructed to begin active motion at the wrist."

Editorial Explains Status and Cost of Sulfapyridine.—"In *The Journal,* February 11, appeared five communications on sulfapyridine," says an editorial in *The Journal of the American Medical Association* for May 6.

"One was a report of the Association's Council on Pharmacy and Chemistry in which the Council recommended that the preparation be not licensed for sale in interstate commerce at that time. Under the new food and drugs act we have advanced greatly in the commercial introduction of new products. For the first time a preliminary survey of the potentiality for good and for harm preceded the exploitation of a drug. The medical profession had opportunity of being informed and its representatives consulted about the drug before any preparation was placed on the open market.

"After the Council had published its preliminary report, much evidence was assembled. March 2 *The Journal* sent inquiries to all investigators who had clinical experience with the product during the period between its availability for experimental use and its introduction on the market. Replies were received from about one hundred investigators.

"The results of these investigations yield two significant observations: first, sulfapyridine is a drug of exceedingly great value in certain cases of pneumonia; second, like sulfanilamide, it is a drug that needs careful supervision. Its use may probably give rise to as many side reactions as sulfanilamide, if not more—for instance, hematuria.

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"Sulfapyridine was licensed for sale in interstate commerce on or about March 10. The Council and *The Journal* approve the action taken by the government in releasing the drug at that time. The final survey by the Food and Drugs Administration was carefully conducted and warranted the release. At present *The Journal* is overwhelmed with papers that have been sent in by various investigators. *The Journal* is grateful for these contributions. Since, however, most of the original articles are merely confirmatory of work already published, it has been necessary for *The Journal* to accept only a few articles. Manuscripts dealing with unusual side reactions or unusual toxic effects or papers reporting extended studies will of course be given special consideration.

"Several physicians and organizations have sent inquiries to the headquarters of the American Medical

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Association asking for an explanation of the relatively high cost of sulfapyridine—approximately 10 cents for a 5 grain tablet in lots of 1,000. A number of factors probably enter into the situation. The drug is patented and therefore not available to free competition. May & Baker, the English concern, assigned its patent rights to Merck & Company of New York. The Calco Chemical Company, it is also understood, claims that it is entitled to a patent and has filed interference claims. One of the ingredients for making the drug, pyridine, has skyrocketed in price from about 35 cents a gallon to approximately $1.75 a gallon. Of course, the introduction of any new drug entails tremendous expense, because of the high cost of investigation; in addition, much of the drug must be given free to investigators. For this outlay the firms must be repaid.

"That the drug might be available and not withheld because of legal complications due to the patent situation, the Calco Chemical Company—a member of the American Cyanamid Corporation—and Merck & Company apparently entered into an agreement whereby the Lederle Laboratories of New York—also a member of the American Cyanamid Corporation—would be the outlet for the pharmaceutic and medical distribution of the drug. The Lederle Laboratories, it will be recalled, have contributed greatly to the development of serums for the treatment of pneumonia, thus being concerned simultaneously with biologic and chemotherapeutic agents.

"Even with the high price of sulfapyridine, the cost of treatment is considerably less than with the use of antipneumococcus serum. No doubt the commercial investments will soon be equalized, and there is reason to hope that the price of sulfapyridine may be materially reduced in the near future."

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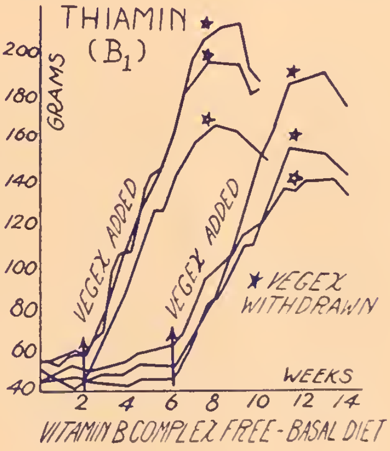

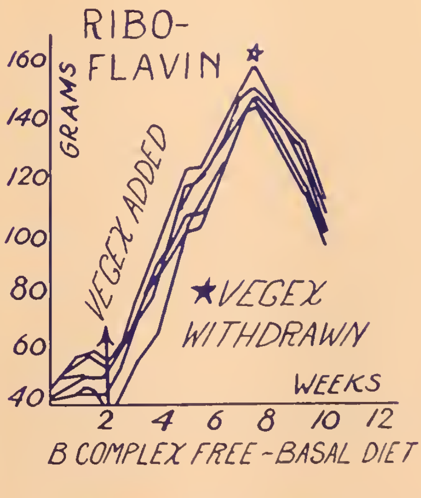

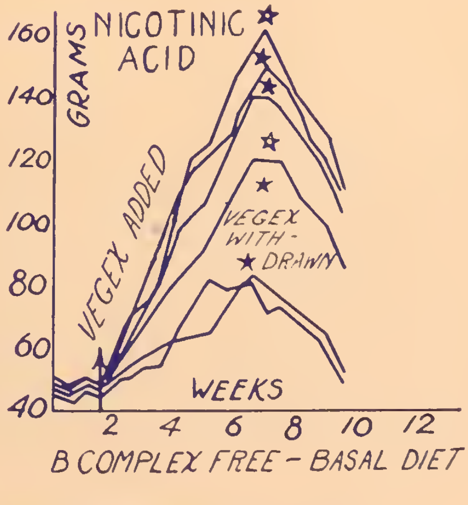

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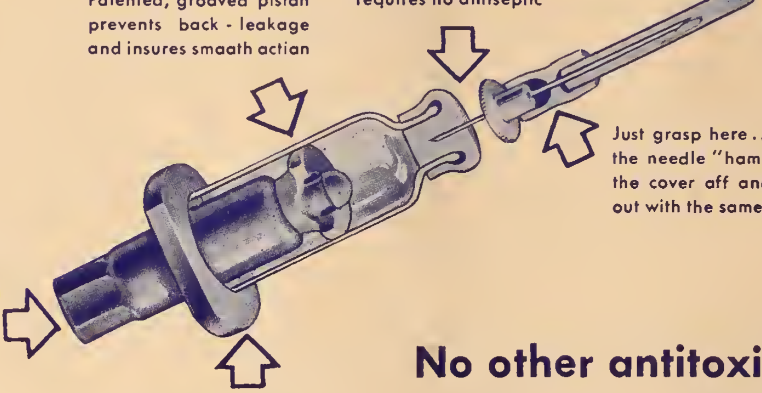
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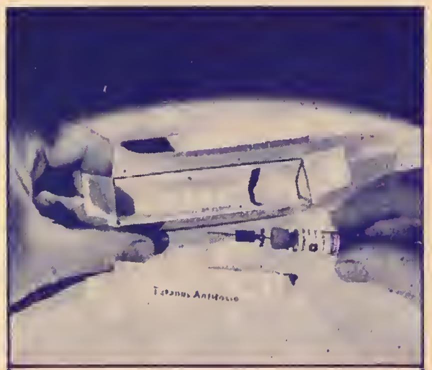

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Executive Committee

The President, the President-elect, the Speaker of the House of Delegates, the Chairman of the Council, the Chairman of the Auditing Committee, the Chairman of the Committee on Public Relations, the Past President, the Secretary-Treasurer, and the Editor. (T. Henshaw Kelly, chairman; George H. Kress, secretary.)

Auditing Committee

O. D. Hamlin	Oakland	1939
T. Henshaw Kelly (Chairman)	San Francisco	1939
Philip K. Gilman	San Francisco	1939

Members of the Auditing Committee are appointed each year by the Chairman of the Council.

Committee on Associated Societies and Technical Groups

William H. Geistweit	San Diego	1939
John V. Barrow (Chairman)	Los Angeles	1940
Edwin L. Bruck	San Francisco	1941

Committee on Health and Public Instruction

W. R. P. Clark	San Francisco	1939
Benjamin W. Black	Oakland	1940
Fred B. Clarke (Chairman)	Long Beach	1941

Committee on History and Obituaries

J. Marion Read	San Francisco	1939
A. Elmer Belt	Los Angeles	1940
Frank R. Makinson (Chairman)	Oakland	1941

Secretary ex officio
Editor ex officio

Committee on Hospitals, Dispensaries and Clinics

W. Earl Mitchell (Chairman)	Oakland	1939
Karl L. Schaupp	San Francisco	1940
George Dawson	Napa	1941

Committee on Industrial Practice

Philip Stephens (Chairman)	Los Angeles	1939
Harry E. Zaiser	Orange	1940
Morton R. Gibbons	San Francisco	1941

Committee on Medical Defense

Fred R. De Lappe	Modesto	1939
John P. Nuttall	Santa Monica	1940
George G. Reinle (Chairman)	Oakland	1941

Committee on Medical Economics

William R. Molony, Sr.	Los Angeles	1939
Edward M. Pallette	Los Angeles	1940
John H. Graves (Chairman)	San Francisco	1941

Committee on Medical Education and Medical Institutions

Loren R. Chandler (Chairman)	San Francisco	1939
John B. Doyle	Los Angeles	1940
B. O. Raulston	Los Angeles	1941

Committee on Membership and Organization

Dewey R. Powell	Stockton	1939
G. Dan Delprat	San Francisco	1940
George D. Maner (Chairman)	Los Angeles	1941

Committee on Postgraduate Activities

F. F. Gundrum	Sacramento	1939
John C. Ruddock (Chairman)	Los Angeles	1940
F. E. Clough	San Bernardino	1941

Secretary ex officio

Committee on Publications

Oscar Reiss	Los Angeles	1939
Ralph Eusden (Chairman)	Los Angeles	1940
Ruggles A. Cushman	Talmage	1941

Secretary ex officio
Editor ex officio

Committee on Public Policy and Legislation

T. Henshaw Kelly	San Francisco	1939
E. T. Remmen	Glendale	1940
Junius B. Harris (Chairman)	Sacramento	1941

President ex officio
President-elect ex officio

Committee on Scientific Work

F. M. Pottenger	Monrovia	1939
Lemuel P. Adams	Oakland	1940
J. Homer Woolsey	Woodland	1941

William H. Barrow, Secretary of Section on General Medicine, ex officio

Ray B. McCarty, Secretary of Section on General Surgery, ex officio

George H. Kress (Chairman), ex officio.

Committee on Public Relations

The Committee on Public Relations consists of the chairmen of the following standing committees and of certain general officers of the Association, all serving ex officio. The chairman of the committee is George G. Reinle, the secretary is George H. Kress. The director of the Department of Public Relations is George H. Kress. The chairman of the Committee on Public Relations is ex officio a member of the Council.

Fred B. Clarke	Chair., Com. on Health and Public Instruction
W. Earl Mitchell	Chair., Com. on Hospitals, Dispensaries, Clinics
Philip Stephens	Chair., Com. on Industrial Practice
George G. Reinle	Chair., Com. on Medical Defense
George D. Maner	Chair., Com. on Membership and Organization
John H. Graves	Chair., Com. on Medical Economics
Junius B. Harris	Chair., Com. on Public Policy and Legislation
Alson R. Kilgore	Chair., Cancer Commission
John C. Ruddock	Chair., Com. on Postgraduate Activities
William W. Roblee	President of California Medical Association
Charles A. Dukes	President-elect
George H. Kress	Secretary-Treasurer

Communications for the Public Relations Department should be addressed to the Director, George H. Kress, M. D., Room 2004, 450 Sutter Street, San Francisco.

Cancer Commission

Alson R. Kilgore (Chairman)	San Francisco	1939
Henry J. Ullmann	Santa Barbara	1939
Clarence G. Toland	Los Angeles	1939
Charles A. Dukes	Oakland	1940
Lyell C. Kinney (Vice-Chairman)	San Diego	1940
Otto H. Pflueger (Secretary)	San Francisco	1940
Orville Meland (Sec'y for Southern Section)	Los Angeles	1941
A. Herman Zeiler	Los Angeles	1941
Gertrude Moore	Oakland	1941

Communications for the Cancer Commission should be addressed to the Secretary, Otto H. Pflueger, M. D., Room 2004, 450 Sutter Street, San Francisco.

FOREWORD

Editor's Note.—*For many years, the California Medical Association has printed annually a Membership Directory, some issues having more than two hundred pages. In recent years, the Board of Medical Examiners of the State of California, with headquarters at 420 State Office Building, Sacramento, has also printed a directory, containing the name, date of birth, years of licensures in different states, and the office address of every physician and surgeon licensed under its jurisdiction. The State Board Directory has also contained much other information concerning the Medical Practice Act, and narcotic and other laws related to healing-art practice in California. A copy of each year's directory is sent to every physician and surgeon who has a license to practice in California.*

Directories of the California Medical Association brought off the press in the past have also presented historical and other information of similar nature.

In order to avoid duplication of printing and other costs, the California Medical Association in the last few years has printed a membership roster giving the names of members and the city or location in which they practice, with key numbers to indicate county medical society membership. This information, when used in connection with that given in the directory of the State Board of Medical Examiners, should answer all ordinary needs.

For additional information, inquiry should be made of the secretaries of the California Medical Association or the Board of Medical Examiners of the State of California.

For reference convenience, California and Western Medicine *is printing this Membership Roster, containing the names of all members through date of March 1, 1939, as a supplement to its March issue. For possible future use, members are advised to place this Membership Roster Supplement in their library files.*

ROSTER OF COUNTY MEDICAL SOCIETIES. CALIFORNIA MEDICAL ASSOCIATION

(County society secretaries are requested to promptly notify "California and Western Medicine" when changes are indicated in their roster information.)

Alameda County Medical Association

2404 Broadway, Oakland

President, Frank H. Bowles, 426 Seventeenth Street, Oakland.

Secretary, Gertrude Moore, 2404 Broadway, Oakland.

Meeting, *Third Monday, 8:15 p. m., Hunter Hall, Oakland.*

Butte County Medical Society

President, E. L. Meyers, Fourth Street and Broadway, Chico.

Secretary, J. O. Chiapella, 131 Broadway, Chico.

Meeting, *Second Thursday.*

Contra Costa County Medical Society

President, Kaho Daily, 314 Tenth Street, Richmond.

Secretary, Clifford E. Dieterich, 1306 Pomona Avenue, Crockett.

Meeting, *Second Tuesday, 8 p. m.*

Fresno County Medical Society

President, Roland W. Dahlgren, 1006 Mattei Building, Fresno.

Secretary, Lester R. Nielson, 1006 Mattei Bldg., Fresno.

Meeting, *First Tuesday, University-Sequoia Club, Fresno.*

Humboldt County Medical Society

President, Samuel P. Burre, 507 F Street, Eureka.

Secretary, Joseph S. Woolford, 350 E Street, Eureka.

Meeting, *First Thursday.*

Imperial County Medical Society

President, Henry B. Graeser, 115 E. Fifth Street, Holtville.

Secretary, William A. Clarke, Holtville.

Meeting, *Third Tuesday, 7 p. m., Barbara Worth Hotel, El Centro.*

Kern County Medical Society

President, C. I. Mead, Haberfelde Building, Bakersfield.

Secretary, C. S. Compton, 428 C Street, Bakersfield.

Meeting, *Third Thursday, 8:00 p. m.*

Kings County Medical Society

President, P. K. Edmunds, Corcoran.

Secretary, William A. Johnstone, Hanford.

Meeting, *Second Monday, 8 p. m., Legion Hall, Hanford.*

Lassen-Plumas-Modoc County Medical Society

President, C. I. Burnett, Susanville.

Secretary, Fred J. Davis, Jr., Westwood.

Meeting, *On Call.*

Los Angeles County Medical Association

1925 Wilshire Boulevard, Los Angeles

President, William H. Daniel, 1930 Wilshire Boulevard, Los Angeles.

Secretary, George D. Maner, 1925 Wilshire Boulevard, Los Angeles.

Meetings, *First and Third Thursdays, 1925 Wilshire Boulevard, Los Angeles.*

Marin County Medical Society

President, Harry N. Hensler, Home Market Building, San Anselmo.

Secretary, Carl W. Clark, 510 B Street, San Rafael.

Meeting, *Fourth Thursday, 7:00 p. m., Marin Golf and Country Club.*

Mendocino-Lake County Medical Society

President, Robert B. Smalley, Willits.

Secretary, Dallas Wagner, Fort Bragg.

Meeting, *On Call.*

Merced County Medical Society

President, E. M. Soderstrom, Merced.

Secretary, Fred O. Lien, Shaffer Building, Merced.

Meeting, *Third Thursday, Hotel Tioga, Merced.*

Monterey County Medical Society

President, Walter P. Farr, 308 Main Street, Salinas.

Secretary, Herbert Archibald, Salinas National Bank Building, Salinas.

Meeting, *First Thursday.*

Napa County Medical Society

President, Alexander H. McLeish, Veterans Home Hospital, Yountville.

Secretary, M. M. Booth, Bruck Building, St. Helena.

Meeting, *First Wednesday.*

Orange County Medical Society

President, M. W. Hollingsworth, 1806 No. Main Street, Santa Ana.

Secretary, Glenn Curtis, 323 So. Pomona Street, Brea.

Meeting, *First Tuesday, 8 p. m., Chapel of the Orange County Hospital, Orange.*

Placer County Medical Society

President, William M. Miller, Auburn.

Secretary, Robert A. Peers, Colfax.

Meeting, *At Call of President.*

Riverside County Medical Society

President, N. K. Bear, 3655 Fourteenth Street, Riverside.

Secretary, Thomas A. Card, 3616 Main Street, Riverside.

Meeting, *Second Monday, 8 p. m., Library, Riverside Community Hospital.*

Sacramento Society for Medical Improvement

President, Manuel Azevedo, 1027 Tenth Street, Sacramento.

Secretary, Glenn E. Millar, 321 Physicians Building, Sacramento.

Meeting, *Third Tuesday, 8:30 p. m., Auditorium, Sacramento.*

San Benito County Medical Society

President, J. M. O'Donnell, Hollister.

Secretary, L. E. Smith, Hollister.

Meeting, *At Call of President.*

San Bernardino County Medical Society

President, Delbert B. Williams, 1151 D Street, San Bernardino.

Secretary, A. E. Varden, Medico-Dental Building, San Bernardino.

Meeting, *First Tuesday, 8 p. m., San Bernardino County Charity Hospital.*

San Diego County Medical Society

Fourteenth Floor, Medico-Dental Building, 233 A Street, San Diego

President, Hall G. Holder, 1109 Medico-Dental Building, San Diego.

Secretary, C. V. Bernardini, Medico-Dental Building, 233 A Street, San Diego.

Meeting, *Second Tuesday, El Cortez Hotel.*

San Francisco County Medical Society

2180 Washington Street, San Francisco

President, Edwin L. Bruck, 384 Post Street, San Francisco.

Secretary, Stanley H. Mentzer, 2180 Washington Street, San Francisco.

Meetings, *Every Tuesday, 8:15 p. m., 2180 Washington Street, San Francisco.*

San Joaquin County Medical Society

President, N. P. Johnson, Medico-Dental Building, Stockton.

Secretary, George H. Rohrbacher, Medico-Dental Building, Stockton.

Meeting, *First Thursday, 8:15 p. m., Medico-Dental Club Rooms, Stockton.*

San Luis Obispo County Medical Society

President, J. B. V. Butler, 722 Marsh Street, San Luis Obispo.

Secretary, E. M. Bingham, County Health Department, San Luis Obispo.

Meeting, *Third Saturday, 6:30 p. m., Gold Dragon Cafe, San Luis Obispo.*

San Mateo County Medical Society

President, N. D. Morrison, 205 Third Avenue, San Mateo.

Secretary, J. Garwood Bridgman, 205 Third Avenue, San Mateo.

Meeting, *Fourth Wednesday, Benjamin Franklin Hotel, San Mateo.*

Santa Barbara County Medical Society

President, W. H. Johnston, 1515 State Street, Santa Barbara.

Secretary, D. H. McNamara, 317 W. Pueblo Street, Santa Barbara.

Meeting, *Second Monday, Cottage Hospital.*

Santa Clara County Medical Society

President, Cletus S. Sullivan, Bank of America Building, San Jose.

Secretary, Leslie B. Magoon, 652 East Santa Clara Street, San Jose.

Meeting, *Third Wednesday, 8 p. m., Medico-Dental Building, San Jose.*

Santa Cruz County Medical Society

President, John T. Harrington, 10 Cooper Street, Santa Cruz.

Secretary, Samuel B. Randall, 84 Walnut Avenue, Santa Cruz.

Meeting, *First Monday, 7:30 p. m., Club Rio del Mar, Aptos.*

Shasta County Medical Society

President, B. F. Saylor, Redding.

Secretary, Morton J. Murphy, 1542 Market Street, Redding.

Meeting, *Second Monday.*

Siskiyou County Medical Society

President, J. B. McGuire, Mt. Shasta.

Secretary, Victor W. Hart, 113 No. Oregon Street, Yreka.

Meeting, *Sunday on call.*

Solano County Medical Society

President, Ream S. Leachman, 727 Sonoma Street, Vallejo.

Secretary, John W. Green, Box 539, Vallejo.

Meeting, *Second Tuesday, 8 p. m., Casa de Vallejo Hotel, Vallejo.*

Sonoma County Medical Society

President, D. C. Oakleaf, 301A West Street, Healdsburg.

Secretary, T. E. Albers, 600 B Street, Santa Rosa.

Meeting, *Second Thursday.*

Stanislaus County Medical Society

President, John A. Cooper, 1024 J Street, Modesto.

Secretary, Hoyt R. Gant, 403 Beaty Building, Modesto.

Meeting, *Second Friday, 7:30 p. m., Hotel Hughson.*

Tehama County Medical Society

President, O. T. Wood, Red Bluff.

Secretary, R. G. Frey, Red Bluff.

Meeting, *At Call of President.*

Tulare County Medical Society

President, Newton Miller, 231 No. Main Street, Porterville.

Secretary, Ray Cronemiller, Exeter.

Meeting, *Sunday Evening once a month.*

Ventura County Medical Society

President, W. F. Mosher, 34 No. Ash Street, Ventura.

Secretary, A. A. Morrison, 625 Main Street, Santa Paula.

Meeting, *Second Tuesday, Ventura County Country Club.*

Yolo-Colusa-Glenn County Medical Society

President, H. G. Potter, Winters.

Secretary, W. J. Blevins, Jr., Woodland.

Meeting, *First Tuesday.*

Yuba-Sutter County Medical Society

President, P. E. Thunen, I. O. O. F. Building, Marysville.

Secretary, Leon M. Swift, I. O. O. F. Building, Marysville.

Meeting, *First Tuesday.*

OFFICERS OF SCIENTIFIC SECTIONS, CALIFORNIA MEDICAL ASSOCIATION

Anesthesiology

Chairman, John G. Dunlop, 168 So. Kingsley Drive, Los Angeles.
Secretary, Adena C. Dutton, 1955 Broadway, San Francisco.

Dermatology and Syphilology

Chairman, Norman N. Epstein, 450 Sutter Street, San Francisco.
Vice-Chairman, Franklin I. Ball, 6253 Hollywood Boulevard, Hollywood.
Secretary, Arne E. Ingels, 490 Post Street, San Francisco.

Eye, Ear, Nose and Throat

Chairman, Clifford B. Walker, 427 West Fifth Street, Los Angeles.
Vice-Chairman, Harry J. Wiley, 2701 Florence Street, Huntington Park.
Secretary, Dewey R. Powell, 242 No. Sutter Street, Stockton.

General Medicine

Chairman, Howard F. West, 602 Wilshire Medical Building, 1930 Wilshire Boulevard, Los Angeles.
Secretary, William H. Barrow, 1400 Medico-Dental Building, San Diego.

General Surgery

Chairman, Loren R. Chandler, Stanford University Medical School, San Francisco.
Secretary, Ray B. McCarty, 3616 Main Street, Riverside.
Assistant Secretary, Frederick S. Foote, 490 Post Street, San Francisco.

Industrial Medicine and Surgery

Chairman, Harvey G. McNeil, 523 West Sixth Street, Los Angeles.
Vice-Chairman, George H. Sanderson, 242 North Sutter Street, Stockton.
Secretary, John S. Stephens, 1136 W. Sixth Street, Los Angeles.

Neuropsychiatry

Chairman, John B. Doyle, 1930 Wilshire Boulevard, Los Angeles.
Secretary, George S. Johnson, Stanford University Hospital, San Francisco.

Obstetrics and Gynecology

Chairman, George W. Coon, 3770 Twelfth Street, Riverside.
Vice-Chairman, John N. Ewer, 411 Thirtieth Street, Oakland.
Secretary, William Benbow Thompson, 1930 Wilshire Boulevard. Los Angeles.

Pathology and Bacteriology

Chairman, Alvin G. Foord, Huntington Memorial Hospital, Pasadena.
Secretary, Roy W. Hammack, 657 South Westlake Boulevard, Los Angeles.
Assistant Secretary, Paul H. Guttman, 1127 Eleventh Street, Sacramento.

Pediatrics

Chairman, Harold K. Faber, Stanford Hospital, San Francisco.
Secretary, Hartzell H. Ray, 23 Second Avenue, San Mateo.
Assistant Secretary, W. W. Belford, 601 Medico-Dental Building, San Diego.

Radiology

Chairman, Karl M. Bonoff, 1930 Wilshire Boulevard, Los Angeles.
Secretary, Carl D. Benninghoven, Mills Memorial Hospital, San Mateo.

Urology

Chairman, Carl F. Rusche, 905 Taft Building, 1680 North Vine Street, Hollywood.
Secretary, John A. Dougherty, 3115 Webster Street, Oakland.

Delegates and Alternates to the American Medical Association

DELEGATES		ALTERNATES
Elbridge Best, San Francisco	(1938-1939)	Robert S. Stone, San Francisco
Lyell C. Kinney, San Diego	(1938-1939)	Bon. O. Adams, Riverside
J. P. Nuttall, Los Angeles	(1938-1939)	F. M. Pottenger, Los Angeles
George G. Reinle, Oakland	(1939-1940)	Frank R. Makinson, Oakland
Edward M. Pallette, Los Angeles	(1939-1940)	William H. Kiger, Los Angeles
Robert A. Peers, Colfax	(1939-1940)	F. F. Gundrum, Sacramento
William R. Molony, Sr., Los Angeles	(1939-1940)	John C. Ruddock, Los Angeles

Special Committees

Committee on Animal Experimentation

Philip Gilman, Chairman
Charles A. Dukes
Loren R. Chandler

Committee on Arrangements

Mast Wolfson, Chairman	Monterey
Alfred L. Phillips	Santa Cruz
W. M. Gratiot	Monterey
Curtis B. Gorham	Monterey
H. R. Lusignan	Monterey

Association Secretary ex officio

Committee on Maternal Welfare

T. Henshaw Kelly	San Francisco
Lyle G. McNeile	Los Angeles
Ralph J. Thompson	Los Angeles
T. Floyd Bell	Oakland
Hans F. Schluter	Sacramento

Committee on Golden Gate International Exposition

T. Henshaw Kelly, Chairman
Edward M. Pallette
Charles A. Dukes
Karl F. Meyer
Hartley F. Peart

Committee on Hospitals

Louis A. Packard, Chairman	Bakersfield
Axcel E. Anderson	Fresno
Calvert L. Emmons	Ontario

Committee on Syphilis

Howard Morrow, Chairman	San Francisco
Charles W. Barnett	San Francisco
William H. Goeckerman	Los Angeles

Committee on a Qualifying Certificate (Basic Science) Law

George H. Kress, (General Chairman) San Francisco

Morton R. Gibbons, Chairman (for Bay Region), San Francisco

Edward M. Pallette, Chairman (for Southern California), Los Angeles

Junius B. Harris, Chairman (for Remainder of State), Sacramento

Woman's Auxiliary to the California Medical Association

State Auxiliary Officers

President, Mrs. Clifford A. Wright, 454 So. Irving Boulevard, Los Angeles.
President-Elect, Mrs. Frederick N. Scatena, 1400 Forty-first Street, Sacramento.
First Vice-President, Mrs. A. E. Anderson, 1035 Cambridge Street, Fresno.
Second Vice-President, Mrs. George Calvin, 277 Euclid Avenue, Oakland.
Recording Secretary, Mrs. G. Wendell Olsen, 219 Buena Vista Drive, Fullerton.
Corresponding Secretary, Mrs. E. Eric Larson, 126 Fremont Place, Los Angeles.
Treasurer, Mrs. Harry O. Hund, 400 Grand Avenue, San Rafael.

Officers of County Auxiliaries

Alameda County — President, Mrs. Frank Baxter, 33 Bowling Drive, Oakland.
Butte County—President, Mrs. N. T. Enloe, 488 East Third Street, Chico.
Contra Costa County—President, Mrs. Melvin A. Stauffer, Pittsburg.
Fresno County—President, Mrs. C. M. Vanderburgh, 518 Terrace Ave., Fresno.
Kern County—President, Mrs. P. N. Root, 2214 Cedar St., Bakersfield.
Lassen-Plumas-Modoc County — President, Mrs. G. R. Fortson, 912 Lassen Street, Susanville.
Los Angeles County—President, Mrs. William H. Leake, 609 North Palm Drive, Los Angeles.
Marin County—President, Mrs. Bernard J. Conroy, 402 Cascade Drive, Fairfax.
Merced County—President, Mrs. E. M. Soderstrom, 49 Twenty-second Street, Merced.
Monterey County — President, Mrs. Garth Parker, 430 So. Main Street, Salinas.
Orange County—President, Mrs. Hiram Currey, 2101 North Ross Street, Santa Ana.
Riverside County—President, Mrs. W. W. Roblee, 3117 Orange Ave., Riverside.
Sacramento County—President, Mrs. George Spencer, 1915 Twenty-first Street, Sacramento.
San Diego County—President, Mrs. Chester O. Tanner, 2454 Presidio, San Diego.
San Francisco County — President, Mrs. Thomas E. Gibson, 2205 Pacific Avenue, San Francisco.
San Joaquin County—President, Mrs. George K. Wever, 2413 Dwight Way, Stockton.
San Luis Obispo County—President, Mrs. Charles R. Kennedy, 1233 Olive Street, Paso Robles.
San Mateo County — President, Mrs. Carl Benninghoven, 140 Clark Drive, San Mateo.
Santa Barbara County—President, Mrs. H. E. Henderson, 1600 Oramus Road, Santa Barbara.
Santa Clara County—President, Mrs. M. D. Baker, 1142 Lincoln Ave., San Jose.
Santa Cruz County—President, Mrs. Alfred L. Phillips, 220 Escalon Drive, Santa Cruz.
Tulare County—President, Mrs. J. C. McClure, Box 36, Lindsay.

Miscellaneous California Medical Organizations

Department of Public Health of the State of California

San Francisco—State Office Building, McAllister and Larkin Streets, UNderhill 8700.
Sacramento—State Office Building, Tenth and L streets. CApital 2800.
Los Angeles—State Office Building, 217 West First Street. MAdison 1281.
President. Howard Morrow, San Francisco.
Director, Walter M. Dickie, State Building. San Francisco.

California Northern District Medical Society

President—John H. White, Chico.
Secretary—J. Homer Woolsey. Woodland Clinic, Woodland.

Board of Medical Examiners of the State of California

San Francisco, Room 214, 515 Van Ness Avenue.

Los Angeles, 906 State Building.

Sacramento, 420 State Office Building.

President, William R. Molony, Sr., Los Angeles.

Secretary, C. B. Pinkham, Room 214, 515 Van Ness Avenue, San Francisco.

Southern California Medical Association

President, John C. Ruddock, 1930 Wilshire Boulevard, Los Angeles.
Secretary, John B. Doyle, 501 Wilshire Medical Building, 1930 Wilshire Boulevard, Los Angeles.

The Public Health League of California

Executive Secretary. Ben H. Read. San Francisco office, 244 Kearny Street, Phone SUtter 8470, Los Angeles office, Room 563, 1151 South Broadway, Phone PRospect 5711.

MEMBERSHIP ROSTER: C. M. A.

COUNTY SOCIETIES INDICATED BY KEY NUMBERS

This roster gives the list of members for the year 1938. Deceased members are indicated by *.
† Retired. ‡ Transferred to other State Society.

KEY NUMBERS FOR COUNTY MEDICAL SOCIETIES

Key No.	Name
1.	Alameda County Medical Association.
2.	Butte County Medical Society.
3.	Contra Costa County Medical Society.
4.	Fresno County Medical Society.
5.	Humboldt County Medical Society.
6.	Imperial County Medical Society.
7.	Kern County Medical Society.
8.	Kings County Medical Society.
9.	Lassen-Plumas-Modoc County Medical Society.
10.	Los Angeles County Medical Association.
11.	Marin County Medical Society.
12.	Mendocino-Lake County Medical Society.
13.	Merced County Medical Society.
14.	Monterey County Medical Society.
15.	Napa County Medical Society.
16.	Orange County Medical Society.
17.	Placer County Medical Society.
18.	Riverside County Medical Society.
19.	Sacramento Society for Medical Improvement.
20.	San Benito County Medical Society.
21.	San Bernardino County Medical Society.
22.	San Diego County Medical Society.
23.	San Francisco County Medical Society.
24.	San Joaquin County Medical Society.
25.	San Luis Obispo County Medical Society.
26.	San Mateo County Medical Society.
27.	Santa Barbara County Medical Society.
28.	Santa Clara County Medical Society.
29.	Santa Cruz County Medical Society.
30.	Shasta County Medical Society.
31.	Siskiyou County Medical Society.
32.	Solano County Medical Society.
33.	Sonoma County Medical Society.
34.	Stanislaus County Medical Society.
35.	Tehama County Medical Society.
36.	Tulare County Medical Society.
37.	Ventura County Medical Society.
38.	Yolo-Colusa-Glenn County Medical Society.
39.	Yuba-Sutter County Medical Society.

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COUNTY SOCIETY MEMBERSHIP TOTALS

(Year 1938)

County	Members
Alameda County	528
Butte County	30
Contra Costa County	50
Fresno County	128
Humboldt County	34
Imperial County	23
Kern County	55
Kings County	17
Lassen-Plumas-Modoc Counties	17
Los Angeles County	2357
Marin County	45
Mendocino-Lake Counties	29
Merced County	31
Monterey County	60
Napa County	37
Orange County	119
Placer - Eldorado - Nevada - Sierra Counties	38
Riverside County	67
Sacramento County	146
San Benito County	7
San Bernardino County	151
San Diego County	277
San Francisco County	930
San Joaquin County	113
San Luis Obispo County	26
San Mateo County	76
Santa Barbara County	110
Santa Clara County	191
Santa Cruz County	39
Shasta County	14
Siskiyou County	18
Solano County	28
Sonoma County	53
Stanislaus County	43
Tehama County	9
Tulare County	41
Ventura County	40
Yolo-Colusa-Glenn Counties	28
Yuba-Sutter Counties	16
Active members	6021
Associate members	4
Retired members	75
Honorary members	1
Total all members	6101

Seventy-three members died during the year 1938.

Note.—The California Medical Association by-laws provide for an annual directory. Because every member receives the annual directory of the Board of Medical Examiners of the State of California, and in order to avoid the great cost of duplication of such a directory, the California Medical Association Council has decided to print in the official journal a simple roster of members, giving for each member the city or place of residence, with a key number to indicate the county medical society in which membership is held.

For additional information concerning school of graduation, etc., the State Medical Board directory or the central office of the California Medical Association should be consulted.

Errors in the list here printed should be promptly reported to the central office of the California Medical Association, Four Fifty Sutter, San Francisco.

I. ACTIVE MEMBERS

— A —

Name	City	County Society No.
Abbott, C. L.,	*Oakland*	1
Abbott, C. N.,	*Ontario*	21
Abbott, D. L.,	*Bakersfield*	7
Abbott, F. F.,	*Ontario*	21
Abbott, G. K.,	*Ukiah*	12
Abbott, K. H.,	*Ontario*	21
Abbott, L. C.,	*San Francisco*	23
Abbott, U. S.,	*Richmond*	3
Abdun-Nur, A. S.,	*Los Angeles*	10
Abowitz, J.,	*Los Angeles*	10
Abraham, H.,	*Los Angeles*	10
Abraham, S. V.,	*Los Angeles*	10
*Abraham, V. R.,	*Long Beach*	10
Abramson, M. J.,	*Los Angeles*	10
Abrons, Harry,	*Berkeley*	1
Achenbach, L. W.,	*Ventura*	37
Adams, B. A.,	*San Leandro*	1
Adams, B. O.,	*Riverside*	18
Adams, B. W.,	*Oakland*	1
Adams, C. W.,	*San Francisco*	23
Adams, E. L.,	*Galt*	19
Adams, J. H.,	*Crockett*	1
Adams, J. P.,	*Oakland*	1
Adams, L. E.,	*Escondido*	22
Adams, L. P.,	*Oakland*	1
Adams, W. C.,	*Oakland*	1
Adams, W. L., Jr.,	*Fresno*	4
Addis, T.,	*San Francisco*	23
Adelstein, L. J.,	*Los Angeles*	10
Agmar, A. R.,	*San Francisco*	23
Ahlem, J. E.,	*Livermore*	1
Ahrens, C. L.,	*Artesia*	10
Ainley, F. C.,	*Los Angeles*	10
Aird, J. L.,	*Manhattan Beach*	10
Aitkin, H. C.,	*Berkeley*	1
Akesson, H. N.,	*Oakland*	1
Alanson, M. R.,	*San Francisco*	23
Albers, T. E.,	*Santa Rosa*	33
Albert, W.,	*Los Angeles*	10
Albertson, H. K.,	*San Diego*	22
Alberty, W. M.,	*East San Diego*	22
Albi, P.,	*San Francisco*	23
Alcazar, I.,	*Los Angeles*	10
Alcon, D. N.,	*Los Angeles*	10
Alden, B. F.,	*San Francisco*	23
Alden, E.,	*Los Angeles*	10
Alden, J.,	*New York, N. Y.*	23
Alden, W. C.,	*Pasadena*	10
Alderson, H. E.,	*San Francisco*	23
Alderson, V. G.,	*Oakland*	1
Aldrich, A. M.,	*San Diego*	22
Aldrich, W. S.,	*Los Angeles*	10
Alesen, L. A.,	*Los Angeles*	10
Alexander, A. A.,	*Oakland*	1
Alexander, E.,	*Philadelphia, Pa.*	34
Alexander, H. H., Jr.,	*Los Angeles*	10
Alexander, J. H.,	*Chico*	2
Algee, M. J.,	*Compton*	10
Allan, J. T. M.,	*Los Angeles*	10
Allegrini, A. E.,	*Santa Cruz*	29
Allen, A.,	*San Pedro*	10
Allen, A. B.,	*Los Angeles*	10
Allen, C. L.,	*Los Angeles*	10
Allen, C. S.,	*Los Angeles*	10
Allen, D. M.,	*Oakland*	1
Allen, E. G.,	*Patterson*	34
Allen, H. H.,	*Los Angeles*	10
Allen, H. W.,	*San Francisco*	23
Allen, J. R.,	*Los Angeles*	10
Allen, M. R.,	*Fairfax*	11
Allen, O. K.,	*San Francisco*	23
Allen, P. K.,	*San Diego*	22
Allen, R. E.,	*Reedley*	4
Allen, R. W.,	*Huntington Park*	10
Allen, W. B.,	*Oakland*	1
Aller, D. I.,	*Fresno*	4
Allington, H. V.,	*Oakland*	1
Allison, B. S.,	*Long Beach*	10
Allison, C. N.,	*San Diego*	22
Allum, A. W.,	*Glendale*	10
Almada, A. A.,	*Sacramento*	19
Alne, A. E.,	*Fullerton*	16
Alsberge, E. W.,	*Glendale*	10
Alsberge, R. C.,	*Santa Cruz*	29
Alson, S. J.,	*Turlock*	34
Alter, S. M.,	*Los Angeles*	10
Althausen, T. L.,	*San Francisco*	23
Althouse, H. C.,	*Los Angeles*	10
Alward, H. C.,	*Los Angeles*	10
Amaral, E. A.,	*San Jose*	28
Ambrose, C. S.,	*Visalia*	36
Ames, M. H.,	*San Diego*	22
Ames, R. H.,	*Redwood City*	26
Ammann, F. X., Jr.,	*Los Angeles*	10
Amyes, H. W.,	*Huntington Park*	10
Anders, J. C.,	*San Diego*	22
Anderson, A. C.,	*Petaluma*	33
Anderson, A. E.,	*Fresno*	4
Anderson, A. V.,	*Pasadena*	10
Anderson, B. N.,	*Burbank*	10
Anderson, C. M.,	*Hermosa Beach*	10
Anderson, C. R.,	*Los Angeles*	10
Anderson, C. W.,	*Bishop*	10
Anderson, E. A.,	*San Joaquin*	24
Anderson, E. DeM.,	*St. Louis, Mo.*	25
Anderson, E. F.,	*San Francisco*	22
Anderson, E. L.,	*Los Angeles*	10
Anderson, F. K.,	*Los Angeles*	10
Anderson, F. N.,	*Los Angeles*	10
Anderson, F. R.,	*Campbell*	28
Anderson, G. H.,	*San Francisco*	23
Anderson, H., Jr.,	*Los Angeles*	10
Anderson, H. C.,	*Pomona*	10
Anderson, H. E.,	*Culver City*	10
Anderson, J. F.,	*Los Angeles*	10
Anderson, J. G.,	*Petaluma*	33
Anderson, M. X.,	*Los Angeles*	10

NAME	CITY	COUNTY SOCIETY NO.
Anderson, N. P.	*Los Angeles*	10
Anderson, O.	*Santa Monica*	10
Anderson, S. B.	*Burbank*	10
Anderson, S. C.	*Westwood*	10
Anderson, W. M.	*Lompoc*	27
Anderson, W. N.	*Los Angeles*	10
Anderton, H. S.	*San Diego*	22
Andrews, A. V.	*Livingston*	13
Andrews, C. B.	*Sonoma*	33
Andrews, H.	*Los Angeles*	10
Andrews, H. F.	*San Diego*	22
Andrews, H. J.	*Hollywood*	10
Andrews, H. J.	*Los Angeles*	10
Andrews, J. N.	*Los Angeles*	10
Andrews, V. L.	*Los Angeles*	10
Andrews, W. A.	*Yucaipa*	21
Andrus, L. M.	*King City*	14
Ankele, C. W.	*Sacramento*	19
Annis, A. J.	*Los Angeles*	10
Anthony, E. H.	*Stockton*	10
Anton, A. N.	*Los Angeles*	10
Anton, F. L.	*Los Angeles*	10
Appeldorn, H. H.	*Oakland*	1
Apple, W. W.	*El Centro*	6
Arbuthnot, R. E.	*Glendale*	10
Archibald, H. C.	*Salinas*	14
Arehart, A. A.	*Monterey*	14
Ariana, A.	*Los Angeles*	10
Arkush, A. S.	*Santa Monica*	10
Armen, G. H.	*Los Angeles*	10
Armistead, R. B.	*Ventura*	37
Armstrong, E. L.	*Los Angeles*	10
Armstrong, M. I.	*Berkeley*	1
Arnold, F. L.	*Long Beach*	10
Arnold, G. H.	*Moorpark*	36
Arnold, H. J.	*San Jose*	28
Arnold, H. R.	*San Francisco*	23
Arnold, W. F.	*Long Beach*	10
Arnot, P. H.	*San Francisco*	23
Arnov, B.	*Los Angeles*	10
Aronstein, E.	*Fresno*	4
Arthur, J. M.	*Fresno*	4
Arthurs, E.	*San Francisco*	22
Ash, R. L.	*San Francisco*	23
Ashcroft, F. E.	*Chula Vista*	20
Ashley, K. C.	*Huntington Park*	10
Ashley, N. N.	*Oakland*	1
Ashley, R. E.	*San Francisco*	23
Askey, E. V.	*Los Angeles*	10
Askey, J. M.	*Los Angeles*	10
Atkinson, C. E.	*Banning*	18
Atkinson, D. W.	*San Francisco*	23
Atkinson, R. C.	*Philadelphia, Pa.*	17
Atkinson, R. E.	*San Bernardino*	21
Atsatt, R. F.	*Santa Barbara*	27
Atteberry, C. V.	*Inglewood*	10
Atwood, A. C.	*Atascadero*	25
Audrain, L. C.	*Los Angeles*	10
Augspurger, E. D.	*Lodi*	24
Austin, L. C.	*Los Angeles*	10
Austin, R. E.	*Coronado*	22
Austin, T. C.	*Pasadena*	10
Avery, J. W.	*Hollywood*	10
Avery, R. W.	*Los Angeles*	10
Avery, W. J.	*Fresno*	4
Awtrey, H.	*Fresno*	4
Axline, J. T.	*North Hollywood*	10
Ayer, E. W.	*Oakland*	1
Ayers, T. F.	*San Francisco*	23
Ayres, S., Jr.	*Los Angeles*	10
Azevedo, J. A.	*Hayward*	1
Azevedo, J. L., Jr.	*Modesto*	34
Azevedo, M. L.	*Sacramento*	19

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NAME	CITY	COUNTY SOCIETY NO.
Babcock, C. E.	*Los Angeles*	10
Babcock, D. W.	*Placerville*	19
Babcock, E. S., Jr.	*Sacramento*	19
Babcock, J. W.	*Placerville*	19
Babcock, L. G.	*Vernon*	10
Babcock, R. A.	*Willits*	12
Babienco, A. T.	*San Diego*	22
Babington, S. H.	*Berkeley*	1
Baccus, C. F.	*Hollywood*	10
Bachelder, B. B.	*Sebastopol*	33
Bacher, J. A.	*San Francisco*	23
Bachhuber, C. A.	*Los Angeles*	10
Bachmann, G. W.	*Santa Monica*	10
Bachrach, R. J.	*Salinas*	14
Bacigalupi, A. A. J.	*San Francisco*	23
Bacon, L. C.	*Los Angeles*	10
Bacon, S. K.	*Hollywood*	10
Badami, A. G.	*Santa Cruz*	29
Baer, H.	*Elsinore*	18
Baetz, W. G.	*Huntington Park*	10
Bahrenburg, G. E.	*Bakersfield*	7
Bailey, C. A.	*Los Angeles*	10
Bailey, C. O.	*Los Angeles*	10
Bailey, F. J.	*Red Bluff*	35
Bailey, T. E.	*San Francisco*	23
Bailey, W.	*Los Angeles*	10
Bailey, W. E.	*Los Angeles*	10
Baiocchi, A. J.	*San Jose*	28
Baird, C.	*San Bernardino*	21
Baird, C. G.	*Santa Maria*	27
Baird, H. R.	*Sacramento*	19
Baird, M. N.	*Redondo Beach*	10
Bak, E. W.	*Los Angeles*	10
Baker, C. D.	*Los Angeles*	10
Baker, F.	*San Francisco*	23
Baker, G. L.	*San Francisco*	23
Baker, H. V.	*Napa*	15
Baker, J. J.	*West Los Angeles*	10
Baker, M. D.	*San Jose*	28
Baker, M. Q.	*Los Angeles*	10
Baker, R. W.	*Sunland*	10
Baker, S. R.	*Los Angeles*	10
Baker, W.	*Los Angeles*	10
Baker, W. P.	*Santa Ana*	16
Bakewell, B.	*Santa Barbara*	27
Bakke, G. A.	*Oakland*	1
Baldwin, A. K.	*Long Beach*	10
Baldwin, L. G.	*Pasadena*	10
Baldwin, M. C.	*Riverside*	18
Balkins, A. J.	*Los Angeles*	10
Ball, D. R.	*Santa Ana*	16
Ball, E. J.	*Los Angeles*	10
Ball, F. I.	*Los Angeles*	10
Ball, H. A.	*San Diego*	22
Ball, J. D.	*Santa Ana*	16
Ballard, C. H.	*Santa Monica*	10
Ballard, S. E.	*Long Beach*	10
Balyeat, F. S.	*Los Angeles*	10
Bames, H. O.	*Los Angeles*	10
Bancroft, I. R.	*Los Angeles*	10
Bancroft, M. F.	*San Diego*	22
Bandelier, R. H.	*Los Angeles*	10
Banks, A. E.	*San Diego*	22
Banks, E. F.	*Auburn*	17
Banks, G. F.	*San Diego*	22
Banks, W. H.	*San Francisco*	23
Barbanell, R. R.	*Los Angeles*	10
Barber, E. M.	*Oakland*	1
Barber, P. S.	*Porterville*	36
Barbour, N. P.	*Stockton*	24
Barcklow, G. T.	*Mendocino City*	12
Barclay, H. A.	*San Diego*	22
Bardill, J. W.	*Ventura*	37
Barkan, H.	*San Francisco*	23
Barkan, O.	*San Francisco*	23
Barker, H. E.	*Ventura*	37
Barker, J. L.	*Brawley*	6
Barlow, T. H.	*Long Beach*	10
Barmore, M. G.	*Whittier*	6
Barnard, F. S.	*Los Angeles*	10
Barnard, H. D.	*Los Angeles*	10
Barnard, H. D.	*Los Angeles*	10
Barnard, L. B.	*Oakland*	1
Barnes, J. W.	*Stockton*	24
Barnes, L. B.	*Newcastle*	17
Barnes, P. D.	*Loomis*	17
Barnes, R. W.	*Los Angeles*	10
Barnes, S. D.	*Los Angeles*	10
Barnes, W. H.	*Chico*	2
Barnett, C. W.	*San Francisco*	23
Barnett, E. D.	*Santa Rosa*	33
Barnett, G. D.	*San Francisco*	28
Barnhart, W.	*Los Angeles*	10
Baron, P. P.	*Alameda*	1
Barr, A. L.	*San Diego*	22
Barr, J. R.	*Tule Lake*	31
Barr, W. T.	*Fresno*	4
Barrett, G. M.	*San Francisco*	23
Barrette, L. C.	*Sacramento*	19
Barrette, P. C.	*San Jose*	28
Barron, A.	*Stockton*	24
Barron, H. C., Jr.	*Escondido*	22
Barrow, J. V.	*Los Angeles*	10
Barrow, W. H.	*San Diego*	22
Barry, G. L.	*San Jose*	28
Bartle, I. B.	*San Luis Obispo*	25
Bartholomew, J. Y.	*San Francisco*	23
Bartholomew, T. E.	*Calexico*	6
Bartlett, C. L.	*Pasadena*	10
Bartlett, E. I.	*San Francisco*	23
Barton, E. W., Jr.	*Alhambra*	10
Barton, E. W.	*Alhambra*	10
Bascom, F. S.	*Oakland*	1
Bates, C. E. H.	*San Francisco*	23
Bathurst, E. W.	*Etna*	31
Batson, W. C.	*Greenville*	9
Baughman, W. H.	*Oakland*	1
Baumgartner, C. J.	*Los Angeles*	10
Bautista, M. D.	*Stockton*	24
Baxter, C. P.	*San Diego*	22
Baxter, F. S.	*Oakland*	1
Baxter, P. N.	*Oakland*	1
Bay, M. W.	*Los Angeles*	10
Bay, S. G.	*West Los Angeles*	10
Bayley, W. A.	*Los Angeles*	10
Baylis, J. N.	*San Bernardino*	21
Beach, E. W.	*Sacramento*	19
Beall, M. E.	*Patton*	21
Bear, N. K.	*Riverside*	18
Beare, W. K.	*San Francisco*	23
Beard, E. A.	*Inglewood*	10
Beardslee, A.	*San Francisco*	23
Beardsley, J. R.	*San Diego*	22
Beasley, H. E.	*Glendale*	10
Beattie, J. I.	*San Jose*	28
Beattie, W. A.	*Sacramento*	19
Beatty, H. J.	*Clinton, New Jersey*	10
Beatty, J. D.	*Los Angeles*	10
Beauchamp, H. H.	*Sacramento*	19
Beaudoux, H. A.	*Los Gatos*	28
Beaver, H. J.	*Palo Alto*	28
Beaver, M. G.	*Redlands*	21
Beck, G. H.	*Glendale*	10
Beck, H. H.	*Corning*	35
Beck, H. R.	*Los Angeles*	10
Beck, J. A.	*Salinas*	14
Becka, S. J.	*Los Angeles*	10
Becker, G. H.	*San Francisco*	23
Becker, H. F.	*Los Angeles*	10
Becker, W. A.	*Los Angeles*	10
Becker, W. N.	*Sacramento*	19
Beekett, W. A.	*Los Angeles*	10
Beckh, W.	*San Francisco*	23
Beckstrand, G.	*Long Beach*	10
Bedri, M. R.	*Los Angeles*	10
Beebe, J. L.	*Anaheim*	16
Beede, A. H.	*Walnut Creek*	3
Beekler, A. M.	*Santa Maria*	27
Beem, M. D.	*West Los Angeles*	10
Beeman, J. W.	*Torrance*	10
Beerman, H. M.	*Los Angeles*	10
Beerman, W. F.	*San Francisco*	23
Beeson, H. O.	*San Bernardino*	21
Behne, K. F.	*Los Angeles*	10
Behneman, H. M. F.	*San Francisco*	23
Behrendt, R. A.	*Los Angeles*	10
Behrens, H. C.	*Whittier*	10
Beigelman, M.	*Los Angeles*	10
Beil, M. C.	*Upper Lake*	12
Belford, W. W.	*San Diego*	22
Bell, D. P.	*Oakland*	1
Bell, H. G.	*San Francisco*	23
Bell, H. W.	*Bakersfield*	7
Bell, R. M.	*Santa Maria*	27
Bell, T. F.	*Oakland*	1
Bell, W. L.	*Oakland*	1
Bellin, J. J.	*Los Angeles*	10
Belous, L. P.	*Los Angeles*	10
Belove, B.	*Los Angeles*	10
Belt, A. E.	*Hollywood*	10
Belt, R. L.	*Montrose*	10
Beltz, D.	*Lodi*	24
Benbrook, S. P.	*Los Angeles*	10
Bender, W. L.	*San Francisco*	23
Bendlage, G. A.	*Long Beach*	10
Benner, E. A.	*San Mateo*	26
Bennett, C. B.	*Berkeley*	1
Bennett, C. L.	*Los Angeles*	10
Bennett, D. W.	*San Francisco*	23
Bennett, E. S.	*Olive View*	10
Bennett, L. C.	*Los Angeles*	10
Bennett, M. C.	*Berkeley*	1
Bennett, M. G. E.	*El Monte*	10
Bennett, W. W.	*Los Angeles*	10
Bennetts, F. A.	*Los Angeles*	10
Benninger, C., Jr.	*Oroville*	2
Benninghoven, C. D.	*San Mateo*	26
Benson, C. B.	*Modesto*	34
Benson, E. H., Jr.	*Berkeley*	1
Benton, J. J.	*Oakland*	1
Bepler, A. C.	*San Francisco*	23
Berauer, J. M.	*Los Angeles*	10
Berejkoff, K. I.	*San Francisco*	23
Berg, A.	*San Francisco*	23
Berg, G. O.	*Hollywood*	10
Berge, F. E.	*Los Angeles*	10
Berger, A. A.	*San Francisco*	23
Berger, G.	*Los Angeles*	10
Bergman, R. T.	*Los Angeles*	10
Bergmann, J. E.	*Santa Monica*	10
Bergstrom, F. K.	*Los Angeles*	10
Berke, S. D.	*Indio*	18
Berkes, H. A.	*Hollywood*	10
Berkley, H. K.	*Los Angeles*	10
Berkove, A. B.	*Oakland*	1
Berkove, S. E.	*Oakland*	1
Berliner, B.	*San Francisco*	23
Berman, P.	*Pasadena*	10
Bernardini, C. V.	*San Diego*	22
Berne, C. J.	*Los Angeles*	10
Bernstein, A.	*San Francisco*	23
Bernstein, H. C.	*Los Angeles*	10
Bernstein, M. M.	*Los Angeles*	10
Bertero, J.	*Santa Maria*	27
Best, E. J.	*San Francisco*	23
Bettercourt, M. F.	*Watsonville*	29
Bettin, M. E.	*Los Angeles*	10
Bettman, J. W.	*San Francisco*	23
Betts, I. H.	*Visalia*	36
Bewley, M. H.	*Los Angeles*	10
Bice, C. W.	*Oakland*	1
Bicknell, H. E.	*Long Beach*	10
Bieler, H. G.	*Pasadena*	10
Biggers, J. A.	*Los Angeles*	10
Bigler, A. B.	*Chowchilla*	13
Bigotti, R. T.	*San Jose*	28
Bilker, D.	*San Jose*	28
Bill, P. R.	*San Francisco*	23
Billig, H. E., Jr.	*Los Angeles*	10
Billingsley, G.	*Los Altos*	28
Billingsley, U. C.	*Hayward*	1
Bilon, L. V.	*Los Angeles*	10
Bine, R.	*San Francisco*	23
Bingaman, E. W.	*Salinas*	14
Bingaman, W. H.	*Salinas*	14
Bingham, E. M.	*San Luis Obispo*	25
Binkley, R. W.	*Selma*	4
Binkley, T.	*Sacramento*	19

NAME	CITY	COUNTY SOCIETY NO.
Bird, A. A.,	*San Leandro*	1
Birkenstock, C. F.,	*San Diego*	22
Birnbaum, W. D.,	*San Francisco*	23
Bishop, C. R.,	*Long Beach*	10
Bishop, T. E.,	*San Diego*	22
*Bishop, T. W.,	*S. Pasadena*	10
Bissell, A. D.,	*Santa Barbara*	27
Bittner, C. L.,	*Sacramento*	19
Bittner, L. H.,	*Glendale*	10
Bittner, S. P.,	*Glendale*	10
Bivins, T. E.,	*Redwood City*	26
Black, B. W.,	*Oakland*	1
Black, E. C.,	*San Diego*	22
Black, H.,	*Palo Alto*	28
Black, W. C.,	*San Diego*	22
Blackfield, H. M.,	*San Francisco*	23
Blackman, W. H.,	*Indio*	18
Blackmun, E. L.,	*Stockton*	24
Blackmun, R. L.,	*Los Angeles*	10
Blackshaw, J. B.,	*Sonoma*	33
Blahnik, K. B.,	*Pasadena*	10
Blaine, E. S.,	*Los Angeles*	10
Blaisdell, F. E., Jr.,	*Watsonville*	29
Blaisdell, P. C.,	*Pasadena*	10
Blake, C. R.,	*Richmond*	3
Blake, K. W.,	*Los Angeles*	10
Blanchard, L. B.,	*San Jose*	28
Blanchard, T. L.,	*San Jose*	28
Bland, C.,	*Long Beach*	10
Blank, B.,	*Los Angeles*	10
Blatherwick, A. A.,	*Los Angeles*	10
Blatherwick, G. W.,	*Los Angeles*	10
Blecker, R. F.,	*Fresno*	4
Bledsoe, R. W. E.,	*Los Angeles*	10
Blemer, J. W.,	*Diablo*	3
Blevins, W. J.,	*Woodland*	38
Blevins, W. J., Jr.,	*Woodland*	38
Blinn, J. F.,	*Stockton*	24
Bliss, G. L.,	*Long Beach*	10
*Bliss, W. P.,	*Pasadena*	10
Bloch, J. L.,	*San Pedro*	10
Blodgett, H. H.,	*Beverly Hills*	10
Blodgett, W. LeR.,	*Calistoga*	15
*Blond, H. H.,	*Los Angeles*	10
Blondin, E. A.,	*San Diego*	22
Blong, P. H.,	*Alhambra*	10
Blood, J. N.,	*Redwood City*	26
Bloomfield, A. L.,	*San Francisco*	23
Blossom, H. S.,	*Patton*	21
Blum, J.,	*San Jose*	28
Blum, S.,	*San Francisco*	23
Blumenthal, E. L.,	*Oakland*	1
Boardman, W. W.,	*San Francisco*	23
Bobbitt, A. N.,	*Pasadena*	10
Bobbitt, J. D.,	*San Diego*	22
Bock, C.,	*Los Angeles*	10
Boder, E.,	*Los Angeles*	10
Bodlander, J. W.,	*Los Angeles*	10
Bodman, E. W.,	*Pasadena*	10
Bodner, H.,	*Hollywood*	10
Boe, M. R.,	*Alameda*	1
Boeck, W. C.,	*Los Angeles*	10
Boehm, C. A.,	*San Francisco*	23
Boehm, M.,	*Napa*	15
Boehmer, A. C.,	*Lodi*	24
Boericke, C. C.,	*Berkeley*	1
Boess, E. C.,	*Riverside*	18
Boetticher, E. O.,	*Los Angeles*	10
Boge, H. G. C.,	*Oakland*	1
Bogen, E.,	*Olive View*	10
Bogle, S. S.,	*Santa Rosa*	33
Bohm, J. E., Jr.,	*San Francisco*	23
Boland, E. W.,	*Los Angeles*	10
Bolander, L. P.,	*Van Nuys*	10
Bolender, M. C.,	*Walnut Creek*	3
Boles, A.,	*Oakland*	1
Bolin, Z. E.,	*San Francisco*	23
Bolinger, H. J.,	*Lodi*	24
Bolkovatz, J. F.,	*Fresno*	4
Boller, S.,	*Los Angeles*	10
Bollig, H. L.,	*Los Angeles*	10
Bolognino, O. J.,	*San Francisco*	23
Bolstad, H. C.,	*Oakland*	1
Bolze, E. H.,	*San Francisco*	23
Bonar, P. A.,	*San Francisco*	23
Bond, A. L.,	*Lindsay*	36
Bond, E. C.,	*Hanford*	8
Bond, F. M.,	*San Diego*	22
Bond, R. E.,	*San Diego*	22
Bonesteel, H. T. S.,	*Los Angeles*	10
Bonfiglio, J.,	*Hollywood*	10
Bonfiglio, V.,	*Los Angeles*	10
Bonn, H. K.,	*Los Angeles*	10
Bonoff, K. M.,	*Los Angeles*	10
Bonthius, A.,	*Pasadena*	10
Bonura, F.,	*Los Angeles*	10
Bonynge, C. W.,	*Los Angeles*	10
Boone, W. R.,	*Berkeley*	1
Boonshaft, L.,	*Los Angeles*	10
Booth, M. M.,	*St. Helena*	15
Booth, W. T.,	*Coronado*	22
Borden, F. W.,	*San Jose*	28
Borley, R. D.,	*Half Moon Bay*	26
Borley, W. E.,	*San Francisco*	23
Bormann, G. B.,	*Hollywood*	10
Boscoe, A. R.,	*Sacramento*	19
Boscoe, C. T.,	*Oakland*	1
Boskowitz, G. H.,	*San Francisco*	23
Bost, C.,	*San Francisco*	23
Bost, F. C.,	*San Francisco*	23
Bosworth, H. W.,	*Los Angeles*	10
Bothe, R. T.,	*Springfield, Ill.*	22
Botsford, M. E.,	*San Francisco*	23
Bourbon, O. P.,	*Los Angeles*	10
Bowen, A.,	*Los Angeles*	10
Bowen, C. B.,	*Oakland*	1
Bower, A. G.,	*Hollywood*	10
Bower, C. F.,	*Long Beach*	10
*Bowers, P. E.,	*Los Angeles*	10
Bowers, W. S.,	*Los Angeles*	10
Bowles, A. M.,	*Santa Rosa*	33
Bowles, F. H.,	*Oakland*	1
Bowman, P.,	*West Los Angeles*	10
Bowman, P. J.,	*Fort Bragg*	12
Bowman, R. J.,	*Beverly Hills*	10
Boyce, L.,	*Los Angeles*	10
Boyce, W. A.,	*Los Angeles*	10
Boyd, E. F.,	*Los Angeles*	10
Boyd, E. G.,	*Los Angeles*	10
Boyd, H. W.,	*Pittsburgh, Pa.*	10
Boyd, T. O.,	*Long Beach*	10
Boyd, W. H.,	*Long Beach*	10
Boyer, H. R.,	*Glendale*	10
Boyer, J. I.,	*Long Beach*	10
Boyer, K. H.,	*Los Angeles*	10
Boyers, L. M.,	*Berkeley*	1
Boyes, J. H.,	*Los Angeles*	23
Boyle, S. F.,	*San Francisco*	23
Bradford, F. E.,	*Los Angeles*	10
Bradley, M. C.,	*Compton*	10
Brady, A. L.,	*San Rafael*	11
Brady, J. F.,	*Alameda*	1
Braithwaite, W. W.,	*Beverly Hills*	10
Bramhall, R. N.,	*Sacramento*	19
Bramkamp, A. L.,	*Banning*	18
Bramkamp, R. G.,	*Talmage*	12
Bramwell, H. L.,	*Napa*	15
Bramwell, L.,	*St. Louis, Mo.*	21
Branch, W. E.,	*Los Angeles*	10
Brandel, H. M.,	*Los Angeles*	10
Brandenburg, K. C.,	*Long Beach*	10
Brandes, L.,	*Los Angeles*	10
Brandt, F. H.,	*Los Angeles*	10
Brandt, G. C.,	*Los Angeles*	10
Brannon, M.,	*Merced*	13
Bransford, S. G.,	*Suisun*	32
Bransford, M. B.,	*Vallejo*	32
Brastad, J. P.,	*Anaheim*	16
Bray, J. L.,	*Los Angeles*	10
Brazelton, H.,	*Oakland*	1
Breck, L. W.,	*Rochester, Minn.*	11
Breitman, H. B.,	*Los Angeles*	10
Bremerman, L. W.,	*Los Angeles*	10
Breslin, F. J.,	*Los Angeles*	10
Breuer, C. H.,	*San Jose*	28
Breuer, R. G.,	*San Jose*	28
Breyer, J. H.,	*Pasadena*	10
Bricca, C. R.,	*San Francisco*	23
Bricca, E. C.,	*San Francisco*	23
Briden, V. S.,	*Merced*	14
Bridgman, J. G.,	*San Mateo*	26
Bridgman, O.,	*San Francisco*	23
Bridgman, W. R.,	*Hanford*	8
Briggs, C. H.,	*Pasadena*	10
Briggs, G. A.,	*Sacramento*	19
Briggs, LeR. H.,	*San Francisco*	23
Briggs, W. M.,	*Monrovia*	10
Briggs, W. R.,	*Sacramento*	19
Brigham, E.,	*Dinuba*	36
Brigham, F. O.,	*Los Angeles*	10
Brill, J.,	*Long Beach*	10
*Brinckerhoff, E. E.,	*Oakland*	1
Brines, R. J.,	*Santa Barbara*	27
Brink, H. E.,	*Lower Lake*	12
Brinkman, W. F.,	*Long Beach*	10
Briner, C. C.,	*Auburn*	17
Broaddus, C. A.,	*Stockton*	24
Brock, L. H.,	*San Francisco*	23
Brockow, J. L.,	*Los Angeles*	10
Brockway, A.,	*Los Angeles*	10
Brodovsky, D.,	*San Jose*	28
Broemser, M. A.,	*San Jose*	28
Bronfeld, N.,	*Los Angeles*	10
Brooks, C. S.,	*El Centro*	6
Brooks, E. R.,	*Atascadero*	1
Brooks, H. T.,	*Alhambra*	10
Brooks, LeR.,	*San Francisco*	23
Bross, R. B.,	*Venice*	10
Broughton, G. A.,	*Ventura*	37
Brown, A. F.,	*Los Angeles*	10
Brown, A. L.,	*Riverside*	18
Brown, A. L.,	*San Francisco*	23
Brown, B.,	*Sacramento*	19
Brown, B. C.,	*Los Angeles*	10
Brown, B. H.,	*San Ysidro*	22
Brown, B. P.,	*Los Angeles*	10
Brown, C.,	*San Francisco*	23
Brown, C.,	*Santa Barbara*	27
Brown, C. M.,	*Los Angeles*	10
Brown, C. W.,	*San Diego*	22
Brown, C. W.,	*San Diego*	22
Brown, D. C.,	*Santa Ana*	16
Brown, D. F.,	*Redwood City*	26
Brown, E. H.,	*Los Angeles*	10
Brown, E. O.,	*Sacramento*	19
Brown, F. A.,	*Hayward*	1
Brown, F. E.,	*Los Angeles*	10
Brown, G. B.,	*Oakland*	1
Brown, G. D.,	*Pomona*	10
Brown, G. W.,	*Los Angeles*	10
Brown, H. A.,	*Berkeley*	1
Brown, H. A.,	*San Francisco*	23
Brown, H. C.,	*San Jose*	28
Brown, H. L.,	*Los Angeles*	10
Brown, I. DeY.,	*Inglewood*	10
Brown, J. L.,	*San Francisco*	23
Brown, J. M.,	*Los Angeles*	10
Brown, J. M.,	*Eureka*	5
Brown, J. R.,	*Los Angeles*	10
Brown, L. E.,	*Corona*	18
Brown, M. H.,	*Los Angeles*	10
Brown, N. J., Jr.,	*Bakersfield*	7
Brown, P. K.,	*San Francisco*	23
Brown, R.,	*Santa Barbara*	27
Brown, R.,	*San Francisco*	23
Brown, R. E.,	*San Juan Bautista*	20
Brown, R. H.,	*Pasadena*	10
Brown, T. H.,	*Orland*	38
Brown, W. B.,	*Los Angeles*	10
Brown, W. E.,	*Los Angeles*	10
Brown, W. H.,	*Palo Alto*	28
Browne, F. E.,	*Los Angeles*	10
Browne, G. C.,	*Oakland*	1
Brownfield, W. H.,	*Los Angeles*	10
Browning, C. F.,	*Los Angeles*	10
Brownlie, J. W.,	*Vallejo*	32
Brownsberger, C. N.,	*Glendale*	10
Brownsberger, S. B.,	*Los Angeles*	10
Bruck, E. L.,	*San Francisco*	23
Bruckman, F. S.,	*San Francisco*	23
Bruckman, H.,	*Ventura*	37
Bruechert, S. S.,	*Hondo*	10
Bruff, W. C.,	*Whittier*	10
Bruin, M. R.,	*Los Angeles*	10
Brull, A.,	*Los Angeles*	10
Bruman, A. K.,	*San Francisco*	23
Brumbaugh, D. H.,	*Redlands*	21
Brumwell, D.,	*King City*	14
Brunemeier, E. H.,	*Placentia*	16
Brunie, L. J.,	*Pasadena*	10
Brunie, Y. S.,	*Pasadena*	10
Bruning, E. F.,	*Balboa*	16
Brunn, H.,	*San Francisco*	23
Brusco, H. D.,	*San Francisco*	23
Brush, N. H.,	*Santa Barbara*	27
Brust, P. R.,	*San Diego*	22
Bryan, L.,	*San Francisco*	23
Bryant, A. L., Jr.,	*Huntington Park*	10
Bryant, B. L.,	*Los Angeles*	10
Bryant, D. C.,	*Claremont*	10
Bryant, H. E.,	*Los Angeles*	10
Buchanan, R. A.,	*Lodi*	24
Buchner, G. O. H.,	*Bakersfield*	7
Buck, L. W.,	*Ross*	23
Buckell, A. E. T.,	*Oakland*	1
Buckingham, J. R.,	*Los Angeles*	10
Buckley, T. I.,	*Oakland*	1
Buckmann, H. D.,	*Martinez*	3
Bucknam, R. W. E.,	*Hollywood*	10
Budaeff, I. T.,	*Daly City*	26
Budd, G. J.,	*Vallejo*	32
Budd, J. W., Jr.,	*Los Angeles*	10
Bull, E. C.,	*San Francisco*	23
Bullard, C. T.,	*King City*	14
Bulley, E. W.,	*Gustine*	13
Bullis, J. A. E.,	*Los Angeles*	10
Bullis, R. O.,	*Los Angeles*	10
Bullitt, J. B.,	*San Jose*	28
Bullock, A. S.,	*Alhambra*	10
Bullock, L. T.,	*Los Angeles*	10
Bulpitt, H. G.,	*Santa Monica*	10
Bulpitt, J. M.,	*Santa Ana*	16
Bulpitt, P. A.,	*Santa Monica*	10
Bulpitt, Z. E. N.,	*Santa Ana*	16
Bulson, C. H.,	*Napa*	15
Bumgarner, J. W.,	*Richmond*	3
Bumpus, H. C.,	*Pasadena*	10
Bumpus, L. D.,	*Beverly Hills*	10
Bunch, C. C.,	*Los Angeles*	10
Bunnell, S.,	*San Francisco*	23
Bunney, G.,	*Suisun*	29
Burch, B. O.,	*Livermore*	1
Burchfiel, C. M.,	*San Jose*	28
Burden, H. S.,	*Sacramento*	19
Burge, M. H.,	*Los Angeles*	10
Burger, F. A.,	*El Centro*	6
Burger, T. O.,	*San Diego*	22
Burk, E. E.,	*Los Angeles*	10
Burkard, A. F.,	*Santa Barbara*	27
Burke, A. M. B.,	*Alameda*	1
Burke, D. V.,	*Oakland*	1
Burke, E. W.,	*Redlands*	21
Burke, G. R.,	*Alameda*	1
Burke, G. T.,	*Pasadena*	10
Burkelman, A.,	*Los Angeles*	10
Burkett, R. C.,	*Napa*	15
Burkhard, W. G.,	*San Francisco*	23
Burks, F. L. R.,	*Fresno*	4
Burlew, J. M.,	*Santa Ana*	16
Burlingame, R. W.,	*San Francisco*	23
Burnap, S. R.,	*Los Angeles*	10
Burnett, C. I.,	*Susanville*	9
Burnham, C. J.,	*Berkeley*	1
Burnham, C. J., Jr.,	*Berkeley*	1

NAME	CITY	COUNTY SOCIETY NO.
Burnham, DeW. K.	*San Francisco*	23
Burnham, P. S.	*Los Angeles*	10
Burns, B. B.	*Pasadena*	10
Burns, E. M.	*Huntington Park*	10
Burns, G. C.	*Los Angeles*	10
Burns, J. E.	*Huntington Park*	10
Burns, M. B.	*Los Angeles*	10
Burns, T. S.	*San Francisco*	23
Burnside, C.	*Hollywood*	10
Burrall, G. M.	*Los Angeles*	10
Burre, S. P.	*Eureka*	5
Burroughs, P. R.	*Santa Monica*	10
Burrows, J. R.	*San Francisco*	23
Burrows, L. A.	*Anaheim*	16
Burrows, M. T.	*Pasadena*	10
Bursell, A.	*Mountain View*	28
Burtness, H. I.	*Santa Barbara*	27
Burton, F. A.	*San Diego*	22
Burton, W. T.	*Tulare*	36
Burwell, L. C.	*Los Angeles*	10
Bush, H. C.	*Livermore*	1
Bussey, D. G.	*Avalon*	10
Butka, L. J.	*Alhambra*	10
Butler, E.	*San Francisco*	23
Butler, F. O.	*Eldridge*	33
Butler, J. B. V.	*San Luis Obispo*	25
Butler, K. W.	*Madera*	4
Butler, O. W.	*Los Angeles*	10
Butler, W. D.	*San Luis Obispo*	25
Butt, E. G.	*Redondo Beach*	10
Butt, E. M.	*Los Angeles*	10
Butterfield, A. DeF.	*Loma Linda*	21
Butterfield, E. R.	*Burbank*	10
Byars, A. H.	*San Diego*	22
Byers, W. M.	*Van Nuys*	10
Byington, P. C.	*Modesto*	34
Byron, R. L.	*Los Angeles*	10
Byron, W. P.	*Lemoore*	8

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NAME	CITY	COUNTY SOCIETY NO.
Cadwell, E.	*Fontana*	21
Cady, D. W.	*Pasadena*	10
Cady, F. P.	*Los Angeles*	10
Cahen, C. G.	*Los Angeles*	10
Cain, E. F.	*Anaheim*	16
Cain, W. T.	*Gardena*	10
Calahan, L. J.	*Lower Lake*	12
Calaway, A. A.	*Fresno*	4
Caldwell, G. W.	*Los Angeles*	10
Caldwell, H. M.	*La Canada*	10
Callander, C. L.	*San Francisco*	23
Callaway, J. W.	*La Jolla*	22
Callaway, W. O.	*Burlingame*	26
Calvert, E. H.	*San Diego*	22
Calvin, G. F.	*Oakland*	1
Cameron, L. C.	*Santa Ana*	16
Cameron, M. C.	*Los Angeles*	10
Cameron, V. L.	*Los Angeles*	10
Cameron, W. A.	*So. Pasadena*	10
Cammack, B. C.	*Los Angeles*	10
Camp, J. W.	*Whittier*	16
Campbell, C. C.	*Long Beach*	10
Campbell, C. R.	*San Jose*	28
Campbell, D. McL.	*San Francisco*	23
Campbell, G. E.	*Pasadena*	10
Campbell, G. M.	*Southgate*	10
Campbell, H. G.	*Lindsay*	36
Campbell, H. S.	*Los Angeles*	10
Campbell, J. R. U.	*Dunsmuir*	31
Campbell, J. V.	*Oakland*	1
Campbell, L. D.	*San Jose*	28
Campbell, L. G.	*Pasadena*	10
Campbell, M.	*Los Angeles*	10
Campbell, F. McL.	*San Pedro*	10
Campbell, M. P.	*San Francisco*	23
Campbell, R.	*Los Angeles*	10
Campbell, R. A.	*Los Angeles*	10
Campbell, W. M.	*Sacramento*	19
Campiche, P. S.	*San Francisco*	23
Campion, E.	*San Francisco*	23
Campion, G. S.	*San Francisco*	23
Campisi, S.	*San Jose*	28
Canby, C. B.	*Van Nuys*	10
Canelo, C. K.	*San Jose*	28
Canfield, M. C.	*El Centro*	6
Canfield, M. N.	*Redlands*	21
Cannon, F. M.	*San Rafael*	11
Cantoni, A. J.	*San Diego*	22
Capp, C. S.	*San Francisco*	23
Card, J. F.	*Denver, Colorado*	23
Card, T. A.	*Riverside*	18
Carden, J. J.	*Honolulu, T. H.*	1
Carey, T. S.	*Los Angeles*	10
Carey, W. W.	*Gridley*	2
Carlile, M. N.	*Lakeside*	22
Carlson, C. M.	*Santa Rosa*	33
Carlson, E.	*San Francisco*	23
Carlson, E. F.	*Fort Jones*	31
Carlson, F. J.	*Oakland*	1
Carmack, J. C.	*San Bernardino*	21
Carmichael, H.	*Sacramento*	19
*Carpenter, F. L.	*Berkeley*	1
Carpenter, H. C.	*Berkeley*	1
Carpenter, H. L.	*Richmond*	3
Carr, J. L.	*San Francisco*	23
Carroll, R. L.	*Los Angeles*	10
Carroll, W. A.	*San Francisco*	23
Carson, A. B.	*Oakland*	1
Carson, D. A.	*San Francisco*	23
Carson, G. R.	*San Francisco*	23
Carter, A. E.	*North Hollywood*	10
Carter, C. E.	*Pasadena*	10
Carter, F. H.	*San Diego*	22
Carter, M. G.	*Los Angeles*	10
Carter, M. L.	*Carmel*	14
Carter, R. A.	*Long Beach*	10
Carter, R. A.	*Alhambra*	10
Carter, R. H.	*Fresno*	4
Carter, R. V.	*Tarzana*	10
Carter, W. E.	*San Francisco*	1
Carter, W. N.	*Los Angeles*	10
Cartmell, T. M.	*Los Angeles*	10
Cartwright, E. W.	*San Diego*	22
Cartwright, S. W.	*Nubieber*	9
Caruso, T. D.	*Los Angeles*	10
Carver, W. F., Jr.	*Hollywood*	10
Cary, J. A.	*Morgan Hill*	28
Cary, R. J.	*Long Beach*	10
Case, C. E.	*Santa Maria*	27
Case, L. W.	*Pomona*	10
Casey, H. A.	*Oakland*	1
Casey, T. J.	*Oakland*	1
Caskey, C. R.	*Los Angeles*	10
Caspar, P. C.	*Hollywood*	10
Cass, A. B.	*Los Angeles*	10
Cass., D.	*Los Angeles*	10
Cassady, E. S.	*San Pedro*	10
Cassell, I.	*San Jose*	28
Cassidy, F. C.	*Livermore*	1
Castelhun, P.	*San Francisco*	23
Castlen, C. R.	*Glendale*	10
Cates, H. B.	*Los Angeles*	10
Catton, J.	*San Francisco*	23
Cecil, A. B.	*Los Angeles*	10
Cecil, J. J.	*Patton*	21
Cerf, A. E.	*San Francisco*	23
Chabanoff, E.	*San Francisco*	23
Chaffee, B. S.	*Long Beach*	10
Chaffin, G. L.	*Los Angeles*	10
Chaffin, R. C.	*Los Angeles*	10
Chaiken, L. H.	*San Jose*	28
Chaimov, A. S.	*San Francisco*	23
Chain, J. N.	*Eureka*	5
Chain, J. S.	*Eureka*	5
Chalfant, G. O.	*San Francisco*	23
Chalmers, J. F.	*La Jolla*	22
Chaloupka, H. R.	*Los Angeles*	10
Chamberlain, B. H.	*Alhambra*	10
Chamberlain, E. F.	*San Diego*	22
Chamberlin, H. H.	*Glendora*	10
Chambers, S. O.	*Los Angeles*	10
Chamlee, W. F.	*Hanford*	8
Champion, J. A.	*Colton*	21
Chandler, L. R.	*San Francisco*	23
Chaney, L. A.	*Los Angeles*	10
Channell, W. L.	*Oakland*	1
Chapman, G. E.	*San Francisco*	23
Chapman, H. S.	*Stockton*	24
Chapman, J. F.	*Pasadena*	10
Chapman, J. L.	*Los Angeles*	10
Chapman, L. S.	*Los Angeles*	10
Chapman, W. H.	*Blythe*	18
Chappell, A. E.	*Vallejo*	32
Chappell, G. E.	*Sacramento*	19
Chappell, H. W.	*Los Angeles*	10
Charles, H. L.	*Alhambra*	10
Charlesworth, I. E.	*Imola*	15
Charlton, A. T.	*Whittier*	10
Charlton, C. F.	*Pasadena*	10
Charmak, D. D.	*San Francisco*	23
Charnock, D. A.	*Los Angeles*	10
Chase, A. E.	*Santa Ana*	16
Chase, A. S.	*Los Angeles*	10
Chase, E. M.	*Soledad*	14
Chase, F. H.	*Los Angeles*	10
Chavez, M.	*Los Angeles*	10
Cheney, G.	*San Francisco*	23
Cheney, L. D.	*Los Angeles*	10
Cheney, M. C.	*Berkeley*	1
Cheney, W. F.	*San Francisco*	23
Cherry, C. F.	*Los Angeles*	10
Cherry, W. S.	*Rialto*	21
Chesbro, E. J.	*Gilroy*	28
Chesbro, W. O.	*Gilroy*	28
Chessman, F. N.	*Los Angeles*	10
Chew, W. B.	*Oakland*	1
Chiapella, J. O.	*Chico*	2
Childers, L. A.	*San Jose*	28
Childress, M. H.	*Ione*	19
Childrey, J. H.	*Atherton*	26
Chilton, F. N.	*San Jose*	28
Ching, P. S.	*Fresno*	4
Chipman, E. D.	*San Francisco*	23
Chipman, W. D.	*Los Angeles*	10
Chittenden, R. F.	*Burbank*	15
Chouret, E. E.	*Riverbank*	34
Christensen, A. C.	*Glendale*	10
Christensen, E. L.	*Los Angeles*	10
Christensen, G. E.	*Los Angeles*	10
Christensen, W.	*Los Angeles*	10
Christensen, W. M.	*Eagle Rock*	10
Christeson, E. L.	*Los Angeles*	10
Christian, J. T.	*Sacramento*	19
Christian, S. G.	*Sacramento*	19
Christie, R. C.	*Long Beach*	10
Christierson, S. von	*San Francisco*	23
Christman, P. W.	*Sacramento*	19
Christopherson, E. H.	*San Diego*	22
Church, C. H.	*Berkeley*	1
Church, I. O.	*Oakland*	1
Church, M. V.	*San Clemente*	10
Churchill, A. G.	*Coronado*	22
Churchill, J. F.	*San Diego*	22
Cieri, S.	*Oakland*	1
Cilley, H. A.	*San Jose*	28
Citron, J. W.	*Oakland*	1
Clark, A. G.	*San Francisco*	23
Clark, C. W.	*San Rafael*	11
Clark, D. G.	*Santa Paula*	37
Clark, D. M.	*Santa Barbara*	27
Clark, E. B.	*Los Altos*	28
*Clark, E. P.	*Los Angeles*	10
Clark, F. A.	*Riverside*	18
Clark, G. E.	*Santa Monica*	10
Clark, G. S.	*Los Angeles*	10
Clark, H. E.	*Monterey*	14
Clark, H. S.	*Riverside*	18
Clark, I. S.	*Long Beach*	10
Clark, J. A.	*Gilroy*	28
Clark, J. W.	*Santa Rosa*	33
Clark, L. J.	*Hemet*	18
Clark, R. L.	*Sacramento*	19
Clark, T. J.	*Oakland*	1
Clark, V. G.	*San Diego*	22
Clark, W. A.	*Pasadena*	10
Clark, W. A.	*Holtville*	6
Clark, W. F.	*Los Angeles*	10
Clark, W. R. P.	*San Francisco*	23
Clark, W. S.	*Ventura*	37
Clarke, A. F.	*Oakland*	1
Clarke, F. B.	*Long Beach*	10
Clarke, R. M.	*Los Angeles*	10
Clarke, W. T.	*Los Angeles*	10
Clay, H. E.	*San Francisco*	23
Clayton, J. H.	*Los Angeles*	10
Cleary, E. W.	*San Francisco*	23
Cleary, G. G.	*San Francisco*	26
Cleave, D. C.	*Belvedere*	11
Clecak, N. J.	*Oakland*	1
Cleeves, M.	*La Crescenta*	10
Clegg, J. G.	*Long Beach*	10
Clemmer, C. V.	*San Marino*	10
Clemons, E. J.	*Los Angeles*	10
Cline, J. W.	*San Francisco*	23
Clock, C. J.	*Redlands*	21
Cloninger, R. C.	*Los Angeles*	4
Close, F. M.	*San Francisco*	23
Close, K. M.	*Los Angeles*	10
Clough, F. E.	*San Bernardino*	21
Clough, V. R.	*Long Beach*	10
Coate, C. R.	*Whittier*	10
Coate, J. D.	*Oakland*	1
Coates, G. L., Jr.	*Martinez*	3
Cobb, D. M., Jr.	*Los Angeles*	10
Cobb, V. M.	*Stewart, Nevada*	10
Cobbs, P. P.	*Los Angeles*	10
Coblentz, L. B.	*San Francisco*	23
Coblentz, Z. B.	*San Francisco*	23
Cochran, G. H.	*Los Angeles*	10
Cochran, G. V.	*Oakland*	1
Cochran, R. C.	*Yorba Linda*	16
Cocks, C. E.	*Oakland*	1
Cody, B. A.	*San Francisco*	23
Coeur-Barron, F. H.	*Los Angeles*	10
Coffey, E. C.	*Orland*	38
Coffey, G. C.	*Ventura*	37
Coffey, S. E.	*Orland*	38
Coffey, W. B.	*San Francisco*	23
Coffin, H. W.	*Los Angeles*	10
Coghlan, C. C.	*Los Angeles*	10
Cohen, M.	*San Francisco*	23
Cohen, P.	*Santa Maria*	27
Cohn, A. L.	*San Francisco*	23
Cohn, H. J.	*San Francisco*	23
Cohn, J.	*Los Angeles*	10
Cohn, M. L.	*San Francisco*	23
Cohn, R.	*San Francisco*	23
Colburn, J. M.	*Riverside*	18
Colby, E. F.	*Bakersfield*	7
Colby, E. G.	*San Diego*	22
Cole, E. R.	*Sacramento*	19
Cole, F.	*Los Angeles*	10
Cole, W.	*Long Beach*	10
Coleman, B. E.	*Los Angeles*	10
Coleman, D. D.	*Alhambra*	10
Coleman, E. H.	*Fresno*	4
Coleman, F. D.	*Los Angeles*	10
Coller, G. J.	*Los Angeles*	10
Collins, C. D.	*Fresno*	4
Collins, D. C.	*Beverly Hills*	10
Collins, F. K.	*Los Angeles*	10
Collins, J. L.	*Turlock*	34
Collins, J. M.	*San Francisco*	23
Collins, M. C.	*Turlock*	34
Collins, R. F.	*No. Hollywood*	10
Collis, W. H. L.	*Stockton*	24
Collischonn, P.	*San Francisco*	23
Colloff, B.	*San Francisco*	23
Colver, B. N.	*Glendale*	10
Comfort, H. W.	*Fortuna*	5
Commons, E. L.	*Los Angeles*	10
Compton, C. S.	*Bakersfield*	7
Comstock, B. W.	*Los Angeles*	10

NAME	CITY	COUNTY SOCIETY NO.
Comstock, D. D.,	*Los Angeles*	10
Comstock, T. R.,	*Los Angeles*	10
Condit, J. C.,	*Oakland*	1
Condit, J. D.,	*Pasadena*	10
Conforth, E. L.,	*Chula Vista*	16
Congdon, W. R.,	*Santa Cruz*	29
Conger, C. B.,	*San Jose*	28
Conklin, C. M.,	*Glendale*	10
Conlan, F. J. S.,	*San Francisco*	23
Conlan, P. T.,	*Los Angeles*	10
Conley, W. T.,	*Los Angeles*	10
Conn, C. E.,	*Hollywood*	10
Connell, DeB. W.,	*Berkeley*	1
Connell, J. A.,	*Riverside*	18
Conner, A. W.,	*San Jose*	28
Connor, C. L.,	*San Francisco*	23
Conroy, B. J.,	*Fairfax*	11
Conroy, T. F.,	*Palo Alto*	28
Conser, W. H.,	*Guadalupe*	27
Conzelmann, F. J.,	*Stockton*	24
Cooder, H. R.,	*Los Angeles*	10
Coodley, O.,	*Los Angeles*	10
Cook, C. S.,	*Los Angeles*	10
Cook, C. W.,	*Los Angeles*	10
Cook, E. J.,	*Los Angeles*	10
Cook, E. P.,	*San Jose*	28
Cook, J. D.,	*Olive View*	10
Cook, O. S.,	*Sacramento*	19
Cook, W. C.,	*Los Angeles*	10
Cook, W. P.,	*Los Angeles*	10
Cooke, A. B.,	*Los Angeles*	10
Cooke, W. C.,	*San Diego*	22
Cooley, C. L.,	*San Francisco*	23
Coon, G. W.,	*Riverside*	18
Cooper, A. J.,	*San Diego*	22
Cooper, B.,	*Arcata*	5
Cooper, C. L.,	*Los Angeles*	10
Cooper, C. M.,	*San Francisco*	23
Cooper, F. G.,	*Huntington Park*	10
Cooper, G. P.,	*Angels Camp*	24
Cooper, H. J.,	*Fresno*	4
Cooper, J. A.,	*Modesto*	34
Cooper, T. E.,	*Davis*	38
Cooper, W.,	*Palo Alto*	28
Copeland, E. K.,	*Woodland*	38
Copp, E. F. F.,	*La Jolla*	22
Corbin, D. E.,	*San Diego*	22
Cordes, F. C.,	*San Francisco*	23
Cordua, O. B.,	*San Diego*	22
Cornell, H. D.,	*San Diego*	22
Corneille, J. G.,	*Berkeley*	1
Cornell, C. E.,	*Los Angeles*	10
Cornett, W. F.,	*Pasadena*	10
Cornwall, T. W.,	*San Francisco*	23
Corr, W. P.,	*Riverside*	18
Cortright, C. B.,	*Berkeley*	1
Cosgrove, C. P.,	*Los Angeles*	10
Cosgrove, J. B.,	*Los Angeles*	10
Coshow, G. H.,	*Carpinteria*	27
Costa, F. J.,	*San Pedro*	10
Costolow, W. E.,	*Los Angeles*	10
Cottle, C. C.,	*Los Angeles*	10
Cottrell, C. C.,	*Scotia*	5
Cottrell, E. L.,	*San Jose*	28
Cottrell, J. C.,	*Long Beach*	10
Couey, E. J.,	*Fresno*	4
Coughlin, J. H.,	*San Bernardino*	21
Coulter, J. D.,	*Portola*	9
Counter, C. E.,	*Long Beach*	10
Counter, H. M.,	*Buena Park*	16
Couperous, J. J.,	*Rio Vista*	32
Courtright, L. J.,	*San Francisco*	23
Courville, C. B.,	*Los Angeles*	10
Covault, W. I.,	*Costa Mesa*	16
Cowan, A. B.,	*Fresno*	4
Cowan, C. B.,	*San Francisco*	23
Cowgill, C. H.,	*Huntington Park*	10
Cowin, C. C.,	*Hollywood*	10
Cowles, D. C.,	*Fullerton*	16
Cox, A. J., Jr.,	*San Francisco*	23
Cox, B. E.,	*Coalinga*	4
Cox, E. R.,	*Los Angeles*	10
Cox, G. W.,	*San Francisco*	23
Cox, H. T.,	*Los Angeles*	10
Cox, J. E.,	*Coalinga*	4
Cox, T. J.,	*San Francisco*	23
Cox, W. J.,	*San Francisco*	23
Coyle, J. D., Jr.,	*Sacramento*	19
Coyne, A. E.,	*Glendale*	10
Crabtree, E. G.,	*San Diego*	22
Crabtree, E. H.,	*San Diego*	22
*Crabtree, W. C.,	*San Diego*	22
Craft, E. D.,	*Los Angeles*	10
Cragin, R. B.,	*San Jose*	28
Crahan, M. E.,	*Los Angeles*	10
Craig, C. A.,	*Lakeport*	12
Craig, J. B.,	*Uplands*	21
Craig, L. G.,	*Pasadena*	10
Craig, R. G.,	*San Francisco*	23
Craig, S. A.,	*Ontario*	21
Craik, C. W.,	*Venice*	10
Crane, C. C.,	*San Francisco*	23
Crane, E. H.,	*Inglewood*	10
Crane, H. W.,	*Berkeley*	1
Crane, J. J.,	*Los Angeles*	10
Crane, N. F.,	*Los Angeles*	10
Crane, W. R.,	*Los Angeles*	10
Crane, W. W.,	*Oakland*	1
Crase, H. R.,	*Los Angeles*	10
Craven, L. L.,	*Glendale*	10
Craviotto, J. V.,	*Stockton*	24
Crawford, J. W.,	*San Francisco*	23
Crawford, W. W.,	*San Diego*	22
Crease, H. G.,	*Bakersfield*	7
Cress, W. W.,	*Sacramento*	19
Crever, J. W.,	*Susanville*	9
Crew, D. A.,	*San Luis Obispo*	25
Criley, C. H.,	*Los Angeles*	10
Crismon, K. A.,	*Los Angeles*	10
Crisp, N. J.,	*Benicia*	32
Crispin, E. L.,	*Los Angeles*	10
Crockett, H. C.,	*Hayward*	1
Croft, L. E.,	*Santa Monica*	10
Cronan, L. A.,	*Davis*	38
Cronemiller, R. E.,	*Exeter*	36
Crooks, S. A.,	*Loma Linda*	21
Crosby, D.,	*Oakland*	1
Crosby, I. F.,	*Pasadena*	10
Cross, W. W.,	*Oakland*	1
Crossan, J. W.,	*Los Angeles*	10
Crossen, A. S.,	*Sacramento*	19
Crow, L. B.,	*San Francisco*	23
Crowe, H. E.,	*Los Angeles*	10
Crowl, V. C.,	*Huntington Park*	10
Crowley, E.,	*Santa Maria*	27
Crowley, F. L.,	*Patton*	21
Crozier, H. C.,	*Los Angeles*	10
Cruden, A. W.,	*Saticoy*	37
Cruikshank, G. H.,	*San Diego*	22
Crum, H. C.,	*Alameda*	1
Crum, R. A.,	*Oakland*	1
Crumrine, H. C.,	*West Los Angeles*	10
Crusan, R. E.,	*Monrovia*	10
Cryst, J. H.,	*Los Angeles*	10
Cullen, B. R.,	*Long Beach*	10
Cummings, H. R.,	*Los Angeles*	10
Cummings, J. C.,	*Glendale*	10
Cummings, M. A.,	*Chico*	2
Cummings, R. A.,	*Los Angeles*	10
Cummings, R. S.,	*Los Angeles*	10
Cuneo, J. C.,	*San Jose*	28
Cuneo, P. J.,	*Bakersfield*	7
Cunha, F.,	*San Francisco*	23
Cunnane, P. J.,	*Los Angeles*	10
Cunnane, T. B.,	*Los Angeles*	10
Cunningham, R. A.,	*Pasadena*	10
Cunningham, R. L.,	*Los Angeles*	10
Cunningham, R. L.,	*Berkeley*	1
Cunningham, T. M.,	*La Mesa*	22
Cunningham, T. T.,	*Huntington P'k*	10
Cunningham, W. E.,	*Richmond*	3
Curdts, C. E.,	*Oakland*	1
Currey, H. M.,	*Santa Ana*	16
Currie, A. H.,	*Los Angeles*	10
Currlin, A. R.,	*Milpitas*	28
Curtis, C. G.,	*Brea*	16
Curtis, L. E.,	*San Francisco*	19
Cushman, G. F.,	*San Francisco*	23
Cushman, R. A.,	*Talmage*	12
Custer, C. P.,	*Patterson*	34
Custer, L. R.,	*San Francisco*	23
Cutler, O. I.,	*Loma Linda*	21
Cutshaw, C. M.,	*Brawley*	6
Cutter, R. D.,	*Palo Alto*	28
Cutter, R. K.,	*Berkeley*	1
Cutting, J. A.,	*Agnew*	28

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NAME	CITY	COUNTY SOCIETY NO.
DaCosta, A. A.,	*San Diego*	22
Dahleen, H. E.,	*San Jose*	28
Dahlgren, R. W.,	*Fresno*	4
Dail, C. W.,	*Loma Linda*	21
Dailey, W. J.,	*Oakland*	1
Daily, K.,	*Richmond*	3
Dakin, W. B.,	*Los Angeles*	10
Dale, M. B.,	*Pasadena*	10
Dallal, J. M.,	*San Mateo*	26
Dallas, D. A.,	*San Francisco*	23
Dalton, J. W.,	*Santa Barbara*	27
Dalton, M. A.,	*Santa Ana*	16
Daly, L. E.,	*Needles*	21
Dameron, J. D.,	*Stockton*	24
Daniel, W. H.,	*Los Angeles*	10
Daniels, A. C.,	*San Rafael*	11
Daniels, E. H.,	*Long Beach*	10
Dannenberg, B. A.,	*Escondido*	22
Danno, S. P.,	*Los Angeles*	10
Darling, H. H.,	*San Francisco*	23
Dart, A. E.,	*Oakland*	1
Dashiell, W. A.,	*Beverly Hills*	10
Dau, N. J.,	*Fresno*	4
Davenport, J. D.,	*Los Angeles*	10
Davidson, B. R.,	*Brawley*	6
David, R. A.,	*Los Angeles*	10
David y Malig, J. M.,	*Los Angeles*	10
Davis, A. D.,	*San Francisco*	23
Davis, A. S.,	*Oakland*	1
Davis, B. L.,	*San Francisco*	23
Davis, E. A.,	*San Francisco*	23
Davis, F. J.,	*Westwood*	9
Davis, F. J., Jr.,	*Westwood*	9
Davis, H. C.,	*San Francisco*	23
Davis, H. H.,	*El Segundo*	10
Davis, H. J.,	*Sacramento*	19
Davis, H. L.,	*Huntington Park*	10
Davis, H. W.,	*San Francisco*	23
Davis, J. D.,	*Los Angeles*	10
Davis, J. P.,	*Santa Ana*	16
Davis, K. S.,	*Los Angeles*	10
Davis, S. K.,	*Santa Ana*	16
Davis, S. S.,	*Oakland*	1
Davison, C. L.,	*Los Angeles*	10
Davison, L. C.,	*Santa Ana*	16
Davison, S. T.,	*San Francisco*	23
Davitt, G. G.,	*Los Angeles*	10
Davlin, L. P.,	*Gonzales*	14
Dawson, E. C.,	*Niles*	1
Dawson, G. I.,	*Napa*	15
Day, E. C.,	*Valley Center*	16
Day, P. W.,	*Repressa*	19
Day, R. V.,	*Los Angeles*	10
Dayton, G. O.,	*Los Angeles*	10
Deacon, G.,	*Pasadena*	10
Deakers, R. P.,	*Los Angeles*	10
Deakin, S. M.,	*Imola*	15
Deamer, W. C.,	*San Francisco*	23
Dean, J. R.,	*Los Angeles*	10
Deane, L. C.,	*San Francisco*	23
Dearing, B. F.,	*San Francisco*	23
Dearborn, R. R.,	*Madera*	3
Debenham, M. W.,	*San Francisco*	23
de Campos, P. do A. R.,	*Hanford*	8
de Carle, D. W.,	*San Francisco*	23
Decker, C. W.,	*Los Angeles*	10
Decker, R. M.,	*Pasadena*	10
DeEds, E. A.,	*San Francisco*	23
Deering, W. E.,	*Hollywood*	10
Deissler, K. J.,	*San Francisco*	1
Delamere, G. S.,	*Marysville*	39
DeLancey, C. A.,	*San Rafael*	11
DeLappe, F. R.,	*Modesto*	34
della Sala, R.,	*Oakland*	1
De Long, E. W.,	*Hollywood*	10
Delphey, W. E.,	*Pasadena*	10
Delprat, G. D., Jr.,	*San Francisco*	23
Delprat, J. L. P.,	*San Francisco*	23
Dempsey, R. B.,	*Vallejo*	32
Den Dulk, G.,	*Ripon*	24
Dennis, H. O.,	*Beverly Hills*	10
Denton, W. L.,	*Trona*	21
DePuy, C. A.,	*Oakland*	1
Derrick, J. S.,	*Los Angeles*	10
Desch, W. D.,	*Oakland*	1
Desimone, L. O.,	*Los Angeles*	10
Desmond, M. A.,	*Santa Monica*	10
Desparois, G. B.,	*Los Angeles*	10
Desrosier, G. W.,	*Colusa*	38
Desser, A. L.,	*Los Angeles*	10
Detling, F. E.,	*Los Angeles*	10
De Vaul, C. H.,	*Oakland*	1
De Vighne, H. C.,	*Santa Barbara*	27
Devin, S. B.,	*Los Angeles*	10
Dewey, E. B.,	*Pasadena*	10
Dewey, E. T.,	*San Francisco*	23
Dewey, H. G.,	*Yosemite*	13
Dick, P. J.,	*Berkeley*	1
Dickerson, D. G.,	*Los Angeles*	10
*Dickerson, H. W.,	*San Diego*	22
Dickey, C. A.,	*San Francisco*	23
Dickey, C. D., Jr.,	*Los Angeles*	10
Dickey, L. B.,	*San Francisco*	23
Dickie, W. M.,	*Berkeley*	1
Dickinson, A. E.,	*Los Gatos*	28
Dickinson, C. C.,	*McCloud*	31
Dickmann, R. C.,	*Glendale*	10
Dickson, A. J.,	*Glendale*	10
Dickson, E. C.,	*San Francisco*	23
Didier, F. W.,	*Wheatland*	39
Diederich, O. P.,	*Fresno*	4
Diefenbach, W. E.,	*La Jolla*	22
Dieffenbacher, P. F.,	*Vallejo*	31
Diepenbrock, A. B.,	*San Francisco*	23
Diesner, H. G.,	*Sunnyvale*	27
Dietderich, C. E.,	*Crockett*	3
Dieterle, K. L.,	*Los Angeles*	10
Dietrich, F. S.,	*Portland, Oregon*	24
Dietrich, H.,	*Los Angeles*	10
Dietz, H. L.,	*Oakland*	1
Diggs, C. S.,	*Los Angeles*	10
Dignan, H. H.,	*San Francisco*	23
*Dillon, E. T.,	*Los Angeles*	10
Dillon, J. R.,	*San Francisco*	23
Dillon, V. M.,	*San Francisco*	23
Diven, G. R.,	*Los Angeles*	10
Dixon, C. D.,	*Venice*	10
Dixon, C. E.,	*Los Angeles*	10
Dixon, H. B.,	*San Francisco*	23
Doane, B. L.,	*Pasadena*	10
Doane, C. P.,	*Fresno*	4
Doane, F. L.,	*Red Bluff*	35
Doane, P. S.,	*Pasadena*	10
Dobson, L. G.,	*San Francisco*	23
Dock, G.,	*Pasadena*	10
Dock, W.,	*San Francisco*	23
Dockweiler, R. R.,	*Los Angeles*	10
Dodd, A. M.,	*Los Angeles*	10
Dodge, D. R.,	*Pasadena*	10
Dodge, W.,	*Los Angeles*	10
Doehring, C. F.,	*Pasadena*	10
Dolan, P. E.,	*Livermore*	1
Dole, K. L.,	*Redlands*	21
Dolley, F. S.,	*Los Angeles*	10
Domann, A. H.,	*Orange*	16

NAME	CITY	COUNTY SOCIETY NO.
Donald, W. G.,	*Berkeley*	1
Donaldson, A. N.,	*Santa Ana*	16
Donelan, James P.,	*Los Angeles*	10
Donoher, W. D.,	*Los Angeles*	10
Donohoe, E. C.,	*Glendale*	10
Donovan, M.,	*San Francisco*	23
Dooley, J. B.,	*Compton*	10
Doran, A. V.,	*Vallejo*	32
Dorius, G. R.,	*Oakland*	1
Dormody, H. F.,	*Monterey*	14
Dormody, H. L.,	*Monterey*	14
Doroshow, G. D.,	*Los Angeles*	10
Dorr, W. R.,	*Arlington*	18
Dostal, R. J.,	*Santa Monica*	10
Dougall, J. P.,	*Los Angeles*	10
Dougan, S.,	*San Jose*	28
Dougherty, J. A.,	*Oakland*	1
Dougherty, P. S.,	*Los Angeles*	10
Doughty, J. F.,	*Tracy*	24
Douglass, G. H.,	*Los Angeles*	10
Douglass, P.,	*San Francisco*	23
Dow, J. N.,	*Los Angeles*	10
Dowd, A. W.,	*Santa Monica*	10
Dowd, R. E.,	*San Bernardino*	21
Dowling, S. W.,	*Santa Cruz*	29
Downing, F. H.,	*Fresno*	4
Downing, S. R.,	*Oakland*	1
Downs, L.,	*Hollywood*	10
Doyle, G. F.,	*San Francisco*	23
Doyle, J. B.,	*Los Angeles*	10
Doyle, J. C.,	*Los Angeles*	10
Doyle, J. J. L.,	*Chico*	2
Doyle, O. B.,	*Fresno*	4
Dozier, D. F.,	*Sacramento*	19
Dozier, E.,	*Redding*	30
Dozier, E. G.,	*San Fernando*	10
Dozier, L.,	*Stockton*	24
Dozier, T. J.,	*Antioch*	3
Drace, C. G.,	*Ojai*	37
Dragoo, S. V.,	*Avenal*	8
Drake, D. D.,	*San Francisco*	23
Drake, J. C.,	*Kerman*	4
Drane, W. H.,	*Los Angeles*	10
Draper, D. B.,	*San Jose*	28
Drees, L. A.,	*San Francisco*	23
Drennan, P. G.,	*Oakland*	1
Dresel, R. L.,	*San Jose*	28
Driscoll, J. A.,	*San Francisco*	23
Druckman, J. S.,	*Los Angeles*	10
Drucks, E. S.,	*Oakland*	1
Drummond, T. A.,	*Randsburg*	21
Dryden, F. M.,	*Pasadena*	10
Dryer, D. S.,	*Los Angeles*	10
Dryfoos, H. L.,	*San Francisco*	23
Dubin, N. A.,	*Lincoln*	17
Dudley, H. W.,	*San Rafael*	11
Dueker, H. W.,	*Lone Pine*	36
Dufficy, G. W.,	*Sacramento*	19
Duggan, H.,	*San Francisco*	23
Duggan, R. J.,	*San Francisco*	23
Dukes, C. A.,	*Oakland*	1
Dunbar, W. V.,	*San Pedro*	10
Duncan, J. A.,	*Marysville*	39
Duncan, M. V.,	*Lompoc*	27
Duncan, R. A.,	*Placentia*	16
Duncan, R. D.,	*Los Angeles*	10
Duncan, W. C.,	*Los Angeles*	10
*Dundas, R. C.,	*Los Angeles*	10
Dunievitz, M.,	*Auburn*	17
Dunklee, G. K.,	*Paso Robles*	25
Dunlavy, K. J.,	*Healdsburg*	33
Dunlevy, G. R.,	*Los Angeles*	10
Dunlop, J.,	*Pasadena*	10
Dunn, R. D.,	*San Francisco*	28
Dunn, R. H.,	*San Francisco*	23
Dunne, N. P.,	*Oakland*	1
DuPree, F. F.,	*Los Angeles*	10
Dupuich, L. R.,	*Oakland*	1
Durgin, R. M.,	*Berkeley*	1
Durr, S. A.,	*San Diego*	22
Dutton, A. C.,	*San Francisco*	23
Dutton, M. L.,	*San Francisco*	23
Duvall, E. M.,	*Long Beach*	10
Dye, W. G.,	*Los Angeles*	10
Dyke, L. H.,	*Oakland*	1
Dykes, H. R.,	*Taft*	7
Dysart, B. R.,	*Pasadena*	10

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NAME	CITY	COUNTY SOCIETY NO.
Eager, B. F.,	*San Diego*	22
Eakin, M. A.,	*Fresno*	4
Earel, F.,	*Santa Ana*	16
Earl, H. D.,	*San Pedro*	10
Earle, L. M.,	*Los Angeles*	10
Early, C. E.,	*Los Angeles*	10
Earwood, E. R.,	*Los Angeles*	10
Eastman, B. R.,	*Pasadena*	10
Eastman, W. R.,	*La Jolla*	22
Easton, D. E. F.,	*San Francisco*	23
Eaton, C. D.,	*Oakland*	1
Eaton, H. D.,	*Los Angeles*	10
Eaton, J. L.,	*Berkeley*	1
Eaton, W. H.,	*Bakersfield*	27
Eaves, J.,	*Oakland*	1
Eberhardt, G.,	*Gonzales*	14
Ebert, C. E.,	*Los Angeles*	10
Ebright, G. E.,	*San Francisco*	23
Eccleston, J. O.,	*Stockton*	24
Eckerle, W. J.,	*Wilmington*	10
Eckhardt, W.,	*Los Angeles*	10
Eder, H. L.,	*Santa Barbara*	27
Eder, L. F.,	*Santa Barbara*	27
Edgerton, A. E.,	*San Francisco*	23
Edler, W.,	*Pasadena*	10
Edmonds, F. W.,	*Oakland*	1
Edmunds, P. K.,	*Corcoran*	8
Edson, P. J.,	*Pasadena*	10
Edward, J. T.,	*Pasadena*	10
Edwards, F. A.,	*Los Angeles*	10
Edwards, H. W.,	*Los Angeles*	10
Edwards, J. C.,	*Berkeley*	1
Edwards, M. E.,	*San Francisco*	23
Edwards, W. M.,	*San Rafael*	11
Egan, A. R.,	*San Diego*	22
Egleston, E. F.,	*San Francisco*	23
Ehlers, E. C.,	*Loma Linda*	21
Ehlers, H.,	*Fowler*	4
Ehrke, A. A.,	*Compton*	10
Eichwald, M.,	*Oakland*	1
Eidenmuller, W. C., Jr.,	*San Francisco*	23
Eikenberry, K.,	*Los Angeles*	10
Einhorn, B.,	*Los Angeles*	10
Eisen, E. G.,	*Los Angeles*	10
Eiskamp, E. H.,	*Watsonville*	29
Eklund, O. E.,	*San Francisco*	23
Elder, H. M.,	*San Francisco*	23
Eldredge, R. B.,	*Los Angeles*	10
Eldridge, S.,	*Crockett*	3
Eliaser, M., Jr.,	*San Francisco*	23
Eliason, P. W.,	*San Mateo*	26
Elkins, D. L.,	*Long Beach*	10
Ellefson, O. D.,	*Hughson*	34
Ellik, M.,	*Long Beach*	10
Elliot, A. H., Jr.,	*Santa Barbara*	27
Elliott, A. C.,	*Anaheim*	16
Elliott, A. L.,	*Berkeley*	1
Elliott, H. M.,	*Los Angeles*	10
Ellis, E. D.,	*Altadena*	10
Ellis, G.,	*Berkeley*	1
Ellis, H. O.,	*Chico*	2
Ellis, L. T.,	*Los Angeles*	10
Ellis, L. W.,	*Alhambra*	10
Ellsworth, A. B.,	*Long Beach*	10
Ellwood, P. M.,	*Oakland*	1
Eloesser, L.,	*San Francisco*	23
Elsbach, K.,	*San Francisco*	23
Emerson, C. V.,	*Los Angeles*	10
Emerson, M. L.,	*Oakland*	1
Emery, C. E.,	*San Francisco*	23
Emery, C. K.,	*Los Angeles*	10
Emge, L. A.,	*San Francisco*	23
Emmons, C. L.,	*Ontario*	21
Emmons, L. L.,	*San Bernardino*	21
Empey, L. W.,	*Roseville*	17
Empie, W. M.,	*San Pedro*	10
Ende, F. M.,	*Hollywood*	10
Endres, W. J.,	*Los Angeles*	10
Eneboe, J. B.,	*San Diego*	22
Engel, E. E.,	*San Bernardino*	21
Englehorn, T. D.,	*King City*	14
Engle, H. M.,	*San Francisco*	23
English, C. F.,	*Stockton*	24
English, G. G.,	*Hollywood*	10
Enloe, N. T.,	*Chico*	2
Enos, J. B.,	*Oakland*	1
Enos, M. M.,	*Oakland*	1
Epsteen, A.,	*San Francisco*	23
Epstein, H. C.,	*Los Angeles*	10
Epstein, N. N.,	*San Francisco*	23
Erkenbeck, J. W.,	*San Diego*	22
Erlanger, V. J.,	*San Diego*	22
Ernsberger, G. H.,	*Covina*	10
Escamilla, R. F.,	*San Francisco*	23
Escher, E. W.,	*San Francisco*	23
Eshman, L. A.,	*Los Angeles*	10
Eshoo, D.,	*South Pasadena*	10
Esker, G. C., Jr.,	*Los Angeles*	10
Esnard, R. P.,	*Los Angeles*	10
Esslinger, P. H.,	*San Juan Capistrano*	16
Etter, O. R.,	*Oakland*	1
Eusden, R. B.,	*Long Beach*	10
Evans, H. R.,	*Kernville*	7
Evans, J. H.,	*Highland*	21
Evans, L. M.,	*Pasadena*	10
Evans, N. G.,	*S. Pasadena*	10
Evans, R. D.,	*Los Angeles*	10
Eveleth, R. H.,	*Roseville*	17
Everingham, S.,	*Oakland*	1
Everman, C. C.,	*Point Reyes Station*	11
Every, H. M.,	*Santa Rosa*	32
Ewens, F.,	*Beverly Hills*	10
Ewer, E. N.,	*Oakland*	1
Ewer, J. N.,	*Oakland*	1
Ewing, F. E.,	*Oakland*	1
Ewing, J. P.,	*Los Angeles*	10
Exelby, P. B.,	*Los Angeles*	10
Eymundson, K. S.,	*San Francisco*	23

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NAME	CITY	COUNTY SOCIETY NO.
Faber, H. K.,	*San Francisco*	23
Fabian, J. P.,	*Chico*	2
Facey, F. D.,	*San Fernando*	10
Fagan, R. H.,	*Los Angeles*	10
Fagan, S. F.,	*Los Angeles*	10
Fagerstrom, D. P.,	*San Jose*	28
Fahlen, C. C.,	*San Francisco*	23
Fairbairn, G. F.,	*Belmont*	26
Fairchild, C. H.,	*Woodland*	38
Fairchild, F. R.,	*Woodland*	38
Fairchild, L. H.,	*Carlsbad*	22
Falconer, E. H.,	*San Francisco*	23
Falconer, F. H.,	*Los Angeles*	10
Falconer, R. A.,	*No. Hollywood*	10
Falk, C. C.,	*Eureka*	5
Falk, C. C., Jr.,	*Eureka*	5
Falk, C. L.,	*Eureka*	5
Falk, E. V.,	*Modesto*	34
Falk, H.,	*Visalia*	36
Falk, R. M.,	*Fall River Mills*	30
Fallas, R. E.,	*Los Angeles*	10
Fanning, J. L.,	*Sacramento*	19
Fanson, E.,	*Pasadena*	10
Faris, H. S.,	*Tucson, Ariz.*	18
Farley, C. W.,	*Los Angeles*	10
Farman, G. F.,	*Los Angeles*	10
Farmer, J. L.,	*San Diego*	22
Farnham, R. M.,	*Glendale*	10
Farnsworth, T. K.,	*Long Beach*	10
Farr, W. H.,	*Salinas*	14
Farrage, J.,	*Corona*	18
Farrage, J.,	*Santa Ana*	16
Farrell, J. W.,	*Los Angeles*	10
Farrell, L. W.,	*Sacramento*	19
Farrington, E. D.,	*El Monte*	10
Farrow, E. J.,	*San Diego*	22
Fate, J. C.,	*Inglewood*	10
Fate, L. W.,	*Hawthorne*	10
Fate, M. W.,	*Los Angeles*	10
Fate, W. A.,	*Los Angeles*	10
Fath, A.,	*San Francisco*	13
Faulkner, E.,	*Stockton*	24
Faulkner, J. L.,	*Red Bluff*	35
Faulkner, W. B., Jr.,	*San Francisco*	23
Fay, J.,	*San Francisco*	23
Fearn, J. R.,	*Oakland*	1
Fearon, W. M.,	*Los Angeles*	10
Feeley, M. A.,	*San Francisco*	23
Fegen, S.,	*Los Angeles*	10
Fehrensen, G.,	*Inglewood*	10
Feinberg, H.,	*San Francisco*	23
Feingold, B. F.,	*Los Angeles*	10
Felberbaum, W.,	*Santa Paula*	37
Feldheym, J. S.,	*San Francisco*	23
Feldman, C.,	*Maywood*	10
Feldman, J. F.,	*Los Angeles*	10
Felger, L.,	*Los Angeles*	10
Fellows, A.,	*Los Angeles*	10
Fellows, F. D.,	*San Francisco*	23
Felps, H. E.,	*Riverside*	18
Felsenthal, L.,	*Los Angeles*	10
Fender, F. A.,	*San Francisco*	23
Fenton, W. W.,	*San Bernardino*	21
Ferguson, R. A.,	*Los Angeles*	10
Fernald, J. M.,	*Los Angeles*	10
Fernandez, M. L.,	*Pinole*	3
Fernandez, R.,	*Downey*	10
Fernish, C. A.,	*Santa Clara*	28
Ferrier, P. A.,	*Pasadena*	10
Ferry, F. C.,	*Los Angeles*	10
Fershtand, J. B.,	*San Francisco*	23
Fetter, E. M.,	*San Diego*	22
Fibush, A.,	*San Francisco*	23
Fiegel, F. X.,	*San Bernardino*	21
Field, A. M.,	*Patterson*	34
Field, J. W.,	*La Crescenta*	10
Fielder, R. L.,	*San Francisco*	23
Fielding, G. A.,	*Los Angeles*	10
Fields, M.,	*Los Angeles*	10
Fieseler, W. R.,	*Los Angeles*	10
Filipello, E. A.,	*San Jose*	28
Fillmore, J. R.,	*Strathmore*	36
Finan, A. P.,	*Suisun*	32
Finch, W. C.,	*Los Angeles*	10
Findlay, F. M.,	*San Diego*	22
Findlay, H. V.,	*Santa Barbara*	27
Fine, I. A.,	*Los Angeles*	10
Fine, M.,	*San Francisco*	23
Fink, D. H.,	*Los Angeles*	10
Finkelberg, I. L.,	*San Bernardino*	21
Finnerty, E. J.,	*Sonoma*	33
Finsand, V.,	*San Francisco*	23
Firestone, F.,	*San Francisco*	23
Firor, M. P.,	*Los Angeles*	10
Fischer, S. S.,	*Oakland*	1
Fish, E. S.,	*Beverly Hills*	10
Fish, L. W.,	*Los Angeles*	10
Fishbaugh, E. C.,	*Los Angeles*	10
Fishbon, H. M.,	*San Francisco*	23
Fisher, A. L.,	*San Francisco*	23
Fisher, C.,	*Los Angeles*	10
Fisher, F. D.,	*Oakland*	1
Fisher, R. E.,	*Pomona*	10
Fisher, R. H.,	*Oakland*	1
Fisher, V. L.,	*Long Beach*	10
Fisher, W. L.,	*Pomona*	10
Fist, H. S.,	*Los Angeles*	10
Fitzgerald, J. J.,	*Richmond*	3
Fitzgerald, W. W.,	*Stockton*	24
Fitzgibbon, C. C.,	*Merced*	13
Fitzhugh, W. M., Jr.,	*San Francisco*	23
*Fitzpatrick, E. B.,	*Martinez*	3

NAME	CITY	COUNTY SOCIETY NO.
Flamson, R. J.	*Los Angeles*	10
Flanders, H. B.	*Port Chicago*	3
Flatley, M.	*Weimar*	17
Fleisher, A. J.	*Berkeley*	1
Fleissner, C. M.	*Santa Rosa*	33
Fleming, G. L.	*Boulder Creek*	29
Fleming, H. W.	*San Francisco*	23
Fleming, L. P.	*Sanger*	4
Fleming, S.	*Eureka*	5
Flesher, R. E.	*Gardena*	10
Fletcher, C. D.	*San Francisco*	23
Fletcher, E. G.	*Oakland*	1
Fletcher, H. A.	*San Francisco*	23
Fletcher, R.	*San Francisco*	23
Flewelling, L. M.	*Glendale*	10
Flitcroft, L. M. I.	*Sacramento*	19
Flood, R. G.	*San Francisco*	23
Floreth, O. P.	*Dixon*	32
Flower, K. C.	*Santa Monica*	10
Fluhmann, C. F.	*San Francisco*	23
Flynn, V. P.	*Pasadena*	10
Fogel, E. T.	*Los Angeles*	10
Fogerty, C. A.	*San Francisco*	23
Fogg, E. S.	*Wasco*	7
Folkenberg, A. W.	*Los Angeles*	10
Folkins, F. H.	*Redlands*	21
Folte, A. G.	*San Francisco*	23
Foord, A. G.	*Pasadena*	10
Foote, C. G.	*San Diego*	22
Foote, F. S.	*San Francisco*	23
Forbes, H. J.	*Pasadena*	10
Ford, H. G.	*Richmond*	3
Ford, R. A.	*Los Angeles*	10
Ford, T. F.	*Ontario*	21
Foree, L.	*Oakland*	1
Fornoff, H. S.	*Oakland*	1
Forsythe, J. S.	*San Bernardino*	21
Fortier, R. M.	*Salinas*	14
Fortson, G. R.	*Susanville*	9
Foshay, A. W.	*Oakland*	1
Foster, A. H.	*Brawley*	6
Foster, C. A.	*Pacific Grove*	14
Foster, F.	*San Francisco*	23
Foster, G. A.	*Grass Valley*	17
Foster, H. E.	*Berkeley*	1
Foster, P. A.	*Los Angeles*	10
Foster, P. D.	*Los Angeles*	10
Fouch, F. L.	*San Francisco*	23
Fountain, E. R.	*Merced*	13
Fountain, W. E.	*Merced*	13
Fowler, C. B.	*Oakland*	1
Fowler, D. C.	*Mill Valley*	11
Fowler, G. W. J.	*Santa Clara*	28
Fowler, H. L.	*Los Angeles*	10
Fox, C. M.	*San Diego*	22
Fox, D. S.	*Berkeley*	1
Fox, H. W.	*San Diego*	36
Fox, L. H.	*Bakersfield*	7
Fox, L. P.	*San Jose*	28
Fox, N. C.	*San Bruno*	26
Fox, S. L.	*Los Angeles*	10
Fox, W. F.	*El Centro*	6
Frame, P. W.	*Elk Grove*	19
Francis, C. H.	*Los Angeles*	10
Francis, K. V.	*San Mateo*	26
Francis, R. K.	*Inglewood*	10
Francis, R. M.	*Pasadena*	10
Francis, R. T.	*Santa Ana*	16
Francis, V. C.	*Long Beach*	10
Francis, W. V. C.	*Los Angeles*	10
Francoz, M. A.	*San Francisco*	23
Frandy, M. F.	*Oakland*	1
Frank, J. A.	*Pismo Beach*	25
Franklin, D. M.	*Los Angeles*	10
Franklin, E. A.	*Los Angeles*	10
Franklin, F.	*Ontario*	21
Franklin, W. S.	*Santa Barbara*	27
Fraser, H. E.	*San Francisco*	23
Fraser, L. H.	*Richmond*	3
Fraser, M. L.	*Los Angeles*	10
Frawley, J. M.	*Fresno*	4
Frederickson, H.	*Eldridge*	33
Freedlander, B. L.	*San Francisco*	23
Frees, B. M.	*Los Angeles*	10
Fregeau, A. N.	*San Francisco*	23
Freibrun, J. L.	*Los Angeles*	10
Freidell, H. F.	*Santa Barbara*	27
French, C. E.	*San Francisco*	23
French, E. A.	*San Luis Obispo*	25
French, J. R.	*Los Angeles*	10
French, L. R.	*San Francisco*	23
Freudenthal, L.	*Gridley*	2
Frey, B. A.	*Los Angeles*	10
Frey, R. G.	*Red Bluff*	35
Frey, W. C.	*San Francisco*	23
Freyermuth, O. G.	*San Francisco*	23
Freytag, C. F.	*Los Angeles*	10
Frick, D. J.	*Los Angeles*	10
Fricke, A. A.	*Los Angeles*	10
Friedberger, W.	*Stockton*	24
Friedlander, R. D.	*San Francisco*	23
Friedman, A.	*San Francisco*	26
Friedman, L.	*Los Angeles*	10
Friedmann, M.	*Los Angeles*	10
Friesen, H. J.	*Glendale*	10
Frisch, A.	*Los Angeles*	10
Fritschen, W.	*San Francisco*	23
Frizzell, R. R.	*Pasadena*	10
Froehlich, D. E.	*Oakland*	1
Frohman, B. S.	*Los Angeles*	10
Frost, E.	*Stockton*	24
Frost, G. A.	*Oroville*	2
Frost, K. P.	*Los Angeles*	10
Frudenfeld, J. C.	*Inglewood*	10
Frug, J.	*Berkeley*	1
Fry, L. C.	*San Diego*	22
Fry, O. P.	*Stockton*	24
Fuerstner, P. G.	*San Francisco*	23
Fujikawa, Y. F.	*Terminal Island*	10
Fulkerson, C. R.	*Oakdale*	34
Fuller, J. D.	*Santa Cruz*	29
Fuller, M. B.	*San Diego*	22
Fulmer, C. C.	*San Francisco*	23
Fung, L.	*Sacramento*	19
Furbush, C. G.	*Oakland*	1
Furlong, R. M.	*San Francisco*	11
Futch, C. E.	*Los Angeles*	10

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NAME	CITY	COUNTY SOCIETY NO.
Gaede, A. W.	*Shafter*	7
Gaede, M. S.	*Reedley*	4
Gaffney, G. F.	*San Francisco*	23
Gafford, J. A.	*Huntington Park*	10
Gage, A. E.	*Los Angeles*	10
Gage, A. T.	*Redlands*	21
Gageby, L. H.	*Los Angeles*	10
Gagnon, A. L.	*San Diego*	22
Gailmard, C. R.	*Los Angeles*	10
Galbraith, A.	*Oakland*	1
*Galbraith, G. H.	*Long Beach*	10
Galbraith, H. F.	*Ventura*	37
Gale, W. V.	*Los Angeles*	10
Gallagher, H. F.	*Los Angeles*	10
Gallagher, V. J.	*Los Angeles*	10
Gallant, A. E.	*Los Angeles*	10
Gallant, P. A.	*Huntington Park*	10
Gallegos, P. B.	*Stockton*	24
Galligan, C. A.	*Monterey*	14
Gallup, C. A.	*Los Angeles*	10
Gallwey, J.	*San Francisco*	23
Galt, C. M.	*Manteca*	24
Galvin, A. H.	*Los Angeles*	10
Gamette, D. L.	*Los Angeles*	10
Ganoe, C. V.	*Los Angeles*	10
Gans, C. C.	*Redwood City*	26
‡Gans, C. H.	*Bisbee, Arizona*	10
Gant, H. R.	*Modesto*	34
Garcia, L. C.	*San Francisco*	23
Gardenier, C.	*San Francisco*	23
Gardenier, W. H.	*Pasadena*	28
Gardiner, J. P.	*Los Angeles*	10
Gardner, C. S.	*Oakland*	1
Gardner, F. M.	*San Bernardino*	21
Gardner, F. W.	*Loma Linda*	21
Gardner, H. L.	*San Francisco*	23
Gardner, K. D.	*San Francisco*	23
Gardner, W. E.	*Riverside*	18
Gardner, W. M.	*Los Angeles*	10
Garfield, S. R.	*Los Angeles*	10
Garland, L. H.	*San Francisco*	23
Garner, G. W.	*Taft*	7
Garnett, A. S.	*San Bernardino*	21
Garrett, F. H.	*Camarillo*	37
Garrett, G. F.	*Los Angeles*	10
Garrison, B. E.	*Riverside*	18
Garrison, E. J.	*Blythe*	18
Garrison, J. F.	*Inglewood*	10
Garrison, O. H.	*Oakland*	1
Garrison, W. P.	*Long Beach*	10
Garstang, D. B.	*Los Angeles*	10
Garth, W. L.	*San Diego*	22
Garvin, C. L.	*Livingston*	13
Gaspard, F. J.	*Los Angeles*	10
Gassman, F.	*Los Angeles*	10
Gassman, F. C.	*San Francisco*	23
Gasteiger, E. S.	*Los Angeles*	10
Gates, C. Y.	*San Francisco*	23
Gates, F. K.	*El Monte*	10
Gates, M. G.	*Santa Monica*	10
*Gates, M. J.	*Santa Cruz*	29
Gates, R.	*Minot, N. D.*	27
Gattuccio, B.	*San Jose*	28
Gaulden, C. L.	*Los Angeles*	10
Gauthier, A. E.	*San Francisco*	23
Gay, E. J.	*Stockton*	24
Gay, H. M.	*Pasadena*	10
Gay, LeR. K.	*San Francisco*	23
Gaynor, E. P.	*San Francisco*	23
Geddes, M. A.	*Santa Ana*	16
Geen, R. S.	*Hollister*	20
Gehrels, E.	*San Francisco*	23
Gehrels, F.	*San Mateo*	26
Geiger, J. C.	*San Francisco*	23
Geisler, W. H.	*San Jose*	28
Geistweit, W. H., Jr.	*San Diego*	22
Geith, C. R.	*Riverside*	18
Gelston, C. F.	*San Francisco*	23
Gentry, H. G.	*Redlands*	21
George, A. R.	*Loma Linda*	21
George, J. DeW.	*Los Angeles*	10
George, J. M.	*San Francisco*	23
George, L. H.	*Loma Linda*	21
George, W. A.	*Loma Linda*	21
Gerbode, F. L. A.	*San Francisco*	23
Gericke, O. L.	*Philadelphia, Pa.*	12
Gerisch, H. H.	*Los Angeles*	10
Gerlach, F. C.	*San Jose*	28
Gerlough, R. J.	*Menlo Park*	26
Germann, A. C.	*Los Angeles*	10
Gernand, H. C.	*Los Angeles*	10
Gerrard, C. C.	*Redding*	30
‡Gerstle, M., Jr.	*New York, N. Y.*	23
Gerty, A. V.	*No. Hollywood*	10
Geshelin, H. I.	*Los Angeles*	10
Getze, G. W.	*Carlsbad*	22
Gewertz, L. L.	*Los Angeles*	10
Geyman, M. J.	*Santa Barbara*	27
Ghillotti, A. E.	*Modesto*	34
Ghormley, V. G.	*Fresno*	4
Ghrist, D. M.	*Glendale*	10
Ghrist, O. E.	*Glendale*	10
Giannini, A. H.	*Los Angeles*	23
Gianotti, E. F.	*Long Beach*	9
Giberson, A. F.	*Watsonville*	29
Gibbons, H., III.	*San Francisco*	23
Gibbons, H. W.	*Sacramento*	19
Gibbons, M. R.	*San Francisco*	23
Gibbons, M. R., Jr.	*San Francisco*	23
Gibbs, D. H.	*Los Angeles*	10
Gibbs, R. S.	*San Bernardino*	21
Gibbs, W. M.	*Glendale*	10
Gibson, A. L.	*Los Angeles*	10
Gibson, T. E.	*San Francisco*	23
Gidley, D. S.	*Ontario*	21
Gidoll, S. H.	*San Francisco*	23
Gilbert, B. H.	*San Jose*	28
Gilbert, E. W.	*Los Angeles*	10
Gilbert, J. S.	*Los Angeles*	10
Gilbert, N.	*Van Nuys*	10
Gilbert, Q. O.	*Oakland*	1
Gilbert, R.	*San Francisco*	23
Gilbert, W. H.	*Laguna Beach*	10
Gilbert, W. P.	*San Francisco*	23
Gilcreest, E. L.	*San Francisco*	23
Giles, F. E.	*Los Angeles*	10
Gilfillan, C. W.	*Hollywood*	10
Gilfillan, H. M.	*San Francisco*	23
Gilkey, W. D.	*Long Beach*	10
Gillespie, P. B.	*Santa Ana*	16
Gilliatt, W. H.	*Coalinga*	4
Gilliland, M. L.	*Los Angeles*	10
Gilliland, R. C.	*Huntington Park*	10
Gillis, J. D.	*Los Angeles*	10
Gillis, J. P.	*Los Angeles*	10
Gilman, A. A.	*San Francisco*	23
Gilman, P. K.	*San Francisco*	23
Gilman, P. J., Jr.	*San Francisco*	23
Gingold, B.	*Los Angeles*	10
Ginsburg, H. M.	*Fresno*	4
Ginsburg, J.	*Los Angeles*	10
Ginsburg, S. S.	*Visalia*	36
Giordano, M.	*San Francisco*	23
Giovannetti, R. P.	*San Francisco*	23
Giovinco, J. B.	*San Francisco*	23
Girard, F. R.	*San Francisco*	23
Girdlestone, C. W.	*Riverside*	18
Gius, E. A.	*San Francisco*	23
Glascock, F. L.	*Los Angeles*	10
Glaser, M. A.	*Los Angeles*	10
Glaser, W.	*San Bruno*	26
Glasgow, G. E.	*Los Angeles*	10
Glass, S. J.	*Los Angeles*	10
Glassman, S. C.	*Los Angeles*	10
Gleason, A. L.	*Oakland*	1
Gleeten, S. D.	*Monrovia*	10
Glenn, J. S.	*Exeter*	36
Glenn, LaV. P.	*Folsom*	19
Glenn, R. A.	*Oakland*	1
Glenn, T. H.	*Los Angeles*	10
Glidden, R. Y., Jr.	*Los Angeles*	10
Gliebe, P. A.	*San Francisco*	23
Gloor, E. E.	*Watsonville*	29
Glover, M. F.	*San Francisco*	23
Glyer, R. T.	*Mountain View*	28
Gobar, F. H.	*Fullerton*	16
Gocher, T. E. P.	*San Rafael*	11
Gocke, J. A.	*Los Angeles*	10
Goddard, W. P.	*Mill Valley*	11
Godett, M. R.	*Los Angeles*	10
Godshall, L. D.	*Los Angeles*	10
Godwin, D. E.	*Long Beach*	10
Goeckerman, W. H.	*Los Angeles*	10
Gogol, L. J.	*Los Angeles*	10
Goin, L. S.	*Los Angeles*	10
Goldberg, A. T.	*Fresno*	4
Goldberg, M. B.	*San Francisco*	23
Goldberg, P. H.	*Los Angeles*	10
Goldberg, S. S.	*Los Angeles*	10
Goldberg, V.	*Long Beach*	10
Golden, H. M.	*Los Angeles*	10
Golden, J. H.	*San Francisco*	23
Goldenberg, J. L.	*Los Angeles*	10
Goldman, A.	*San Francisco*	23
Goldman, L.	*San Francisco*	23
Goldman, S. A.	*San Francisco*	23
Goldman, T. H.	*Los Angeles*	10
Goldman, V. S.	*San Francisco*	23
Goldsmith, J. E.	*Los Angeles*	10
Goldstein, J.	*Los Angeles*	10
Goldstein, L. B.	*San Francisco*	23
Goldstein, M. M.	*Fresno*	4
Goldwasser, M.	*Los Angeles*	10
Golitzin, A.	*Hollywood*	10

NAME	CITY	COUNTY SOCIETY NO.
Gomes, J. J.	*Oakland*	1
Gompertz, K. R.	*Berkeley*	1
Goodall, O. P.	*Bakersfield*	7
Goodcell, R. A.	*Los Angeles*	10
Goodman, M.	*Stockton*	24
Goodman, M. J.	*Eureka*	5
Goodman, S. Z.	*Los Angeles*	10
Goodwin, O. E.	*San Francisco*	23
Gorb, R.	*San Francisco*	23
Gordon, G. O.	*Long Beach*	10
Gordon, G. S.	*Los Angeles*	10
Gordon, K. W.	*Los Angeles*	10
Gordon, M. R.	*San Francisco*	23
Gorrell, J. S.	*Los Angeles*	10
Gospe, S. M.	*San Francisco*	23
Gossard, J. E.	*Sierra Madre*	10
Gotanda, W. I.	*Stockton*	24
Gotfredson, H. L.	*So. Pasadena*	10
Gottbrath, N. J.	*Agnew*	28
Gottlieb, A. J.	*Los Angeles*	10
Gottschalk, A.	*San Francisco*	23
Gough, A. S.	*El Segundo*	10
Gouguet, L. J.	*Sacramento*	19
Gould, A. A.	*Los Angeles*	10
Gould, N. B.	*Modesto*	34
Gourley, I.	*Livermore*	1
Gourse, A.	*Sacramento*	19
Gowan, C. H.	*Glendale*	10
Graeser, H. B.	*Holtville*	6
Graeser, H. S.	*Woodland*	38
Graeser, J. B.	*Oakland*	1
Graham, H. B.	*San Francisco*	23
Graham, H. K.	*San Diego*	22
Graham, J. P.	*Los Angeles*	10
Graham, R. E.	*Oakland*	1
Graham, R. S.	*Sacramento*	19
Granger, A. S.	*Los Angeles*	10
Grant, B. E., Jr.	*Hollywood*	10
Grant, J. F.	*Long Beach*	10
Grant, R. F.	*San Francisco*	23
Grantham, D. M.	*Oakland*	1
Gratiot, J. H.	*Monterey*	14
Gratiot, W. M.	*Monterey*	14
Grau, E. C.	*Niles*	1
Graun, R. E.	*Los Gatos*	28
Graves, C. A.	*Beverly Hills*	10
Graves, J. H.	*San Francisco*	23
Graves, J. M.	*San Francisco*	23
Graves, R. V.	*Fullerton*	16
Gray, E.	*Los Angeles*	10
Gray, E. E.	*Marysville*	39
Gray, E. H.	*Woodland*	38
Gray, G. A.	*San Jose*	28
Gray, G. H.	*Oakland*	1
Gray, H.	*San Francisco*	23
Gray, J. P.	*San Francisco*	23
Gray, J. R.	*Carmel*	14
Gray, P. A., Jr.	*Santa Barbara*	27
Gray, R. M.	*Palm Springs*	18
Gray, R. N.	*Hartford, Conn.*	23
Graybill, M. B.	*Escondido*	22
Grayman, H. M.	*Dos Palos*	13
Green, A. S.	*San Francisco*	23
Green, B., Jr.	*Riverside*	18
Green, H. R.	*Palo Alto*	28
Green, J.	*Los Angeles*	10
Green, J. W.	*Vallejo*	32
Green, M. I.	*San Francisco*	23
Green, M. M.	*Stockton*	24
Greenbaum, G. B.	*Los Angeles*	10
Greenbaum, L. H.	*Los Angeles*	10
Greene, H. H.	*Baldwin Park*	10
Greene, W. W.	*San Francisco*	23
Greengo, C. G.	*Los Angeles*	10
Greenman, R. A.	*Stockton*	24
Greenschpoon, R. R.	*Los Angeles*	10
Greenway, H. H.	*Los Angeles*	10
Greenwood, C. F.	*Oakland*	1
Greenwood, E. N.	*San Francisco*	23
Greer, E. D.	*Oakland*	1
Gregg, F. C.	*Calexico*	6
Gregg, H. J.	*Calexico*	6
Gregory, C. A.	*Santa Rosa*	33
Gregory, F. S.	*Redwood City*	26
Gregory, H. L.	*Stockton*	24
Gregory, J. E.	*Pasadena*	10
Gregory, W. A.	*Oakland*	1
Grey, C. A.	*Burbank*	10
Griess, R. O.	*Salinas*	14
Griffin, A. M.	*Oakland*	1
Griffin, W. L.	*Los Angeles*	10
Griffith, A. H.	*Oakland*	1
Griggs, D. E.	*Los Angeles*	10
Griggs, J. F.	*Claremont*	10
Grimmer, E. M.	*Irvington*	1
Griner, E. C.	*Stockton*	24
Grishaw, W. H.	*Los Angeles*	10
Groat, M. J.	*Los Angeles*	10
Groff, S. H.	*Los Angeles*	10
Grogan, R. E.	*Los Angeles*	10
Gronhovd, G. O.	*Santa Paula*	37
Groper, M. J.	*San Francisco*	23
Grosse, A. B.	*San Francisco*	23
Groves, R. L.	*San Francisco*	23
Grow, W. L.	*San Diego*	22
Gruber, F. G.	*Santa Monica*	10
Grundy, G. M.	*Newport Beach*	16
Guedel, A. E.	*Los Angeles*	10
Guenther, L. P.	*Los Angeles*	10
Guerra, A. L.	*Alameda*	1
Guggenheim, L. K.	*Los Angeles*	10
Guidinger, W. E.	*San Pedro*	10
Guido, F. R.	*Visalia*	36
Guinan, E. R.	*Richmond*	3
Gumbiner, A. A.	*Los Angeles*	10
Gummess, K. C.	*Los Angeles*	10
Gummig, E. A.	*Pasadena*	10
Gumpert, M. W.	*Los Angeles*	10
Gunderson, H. J.	*Beverly Hills*	10
Gundrum, F. F.	*Sacramento*	19
Gundrum, L. K.	*Los Angeles*	10
Gundrum, W. H.	*Owensmouth*	10
Gundry, F. J.	*Bakersfield*	7
Gunn, F. G.	*Kelseyville*	15
Gunther, L.	*Los Angeles*	10
Gustafson, A. W.	*Gustine*	13
Gustafson, R. K.	*Pasadena*	10
Guttman, P. H.	*Sacramento*	19

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NAME	CITY	COUNTY SOCIETY NO.
Haag, E. C.	*Philadelphia, Pa.*	19
Haas, S. L.	*San Francisco*	23
Haber, W. J.	*San Francisco*	23
Hadden, D.	*Berkeley*	1
Hadden, D. R.	*Berkeley*	1
Hadden, M. B.	*Berkeley*	1
Haddow, N. W. A.	*Hollywood*	10
Hadley, C. M.	*San Bernardino*	21
Haenszel, A. L.	*San Bernardino*	21
Hagan, B. J.	*San Francisco*	23
Hagedorn, E. F.	*Modesto*	34
Hager, B. H.	*Los Angeles*	10
Hagerty, T. W.	*Camarillo*	37
Hahn, L. W.	*Berkeley*	1
Haig, T. R.	*Sacramento*	19
Haight, F. K.	*Oakland*	1
Haight, L. M.	*Stockton*	24
Haim, A.	*San Francisco*	23
Haines, C. L.	*Altadena*	10
Haines, W. H.	*Etna*	31
Haining, R. B.	*Glendale*	10
Halburg, C. T.	*Glendale*	21
Haldeman, K. O.	*San Francisco*	23
Hale, C. W.	*Pomona*	10
Hale, N. G.	*Sacramento*	19
Haley, P. S.	*San Jose*	28
Hall, A. F., Jr.	*Los Angeles*	10
Hall, C.	*Oakland*	1
Hall, C.	*Los Angeles*	10
Hall, C. C.	*Oakland*	1
Hall, E. H.	*Vernon*	10
Hall, E. M.	*Los Angeles*	10
Hall, G. E.	*Beverly Hills*	10
Hall, G. J.	*Sacramento*	19
Hall, G. P.	*San Jose*	28
Hall, G. S.	*Los Angeles*	10
Hall, H. A.	*Redlands*	21
Hall, H. R.	*Santa Ana*	16
Hall, L. H.	*Riverside*	18
Hall, L. L.	*Montebello*	10
Hall, R. C.	*San Diego*	22
Hall, T. G.	*San Francisco*	23
Halley, E. C.	*Sanger*	4
Halligan, B. E.	*Oakland*	1
Halloran, C. R.	*Los Angeles*	10
Halsey, W. H.	*San Diego*	22
Halverson, G. R.	*San Jacinto*	18
Halverson, W. L.	*Pasadena*	10
Ham, G. H.	*Culver City*	10
Haman, J. O.	*San Francisco*	23
Hambleton, H. G.	*Los Angeles*	10
Hambleton, M. P.	*Fontana*	21
Hamer, C.	*Glendale*	10
Hamer, R. T.	*National City*	22
Hamilton, E. M.	*Los Angeles*	10
Hamilton, G. V.	*Santa Barbara*	27
Hamilton, H. P.	*Santa Monica*	10
Hamilton, J. K., Jr.	*Alameda*	1
Hamilton, L. M.	*Oakland*	1
Hamilton, P. L.	*Chico*	2
Hamilton, P. M.	*Alhambra*	10
Hamilton, R. L.	*Marysville*	39
Hamilton, V. C.	*Oakland*	1
Hamlin, O. D.	*Oakland*	1
Hamlin, R. E.	*Santa Rosa*	33
Hammack, R. W.	*Los Angeles*	10
Hammons, E. B.	*Los Angeles*	10
Hand, D. W.	*San Francisco*	23
Hand, F. B.	*San Francisco*	23
Hand, H. M.	*San Francisco*	23
Hand, L. J.	*San Francisco*	23
Hand, M.	*San Francisco*	23
Hanford, F. W.	*Los Angeles*	10
Hankins, F. D.	*Riverside*	18
Hankins, J. W.	*Azusa*	10
Hanley, B. J.	*Los Angeles*	10
*Hanlon, E. R.	*Los Angeles*	10
Hanlon, E. W.	*San Francisco*	23
Hanlon, H. H.	*Los Angeles*	10
Hanna, C. M.	*San Diego*	22
Hannah, W.	*Long Beach*	10
Hansen, A. M.	*Los Angeles*	10
Hansen, O. J.	*Redding*	30
Hanson, G. B.	*Long Beach*	10
Hanson, J. H.	*San Carlos*	26
Hanson, O. H.	*San Marino*	10
Hanson, S.	*Stockton*	24
Hanten, J. S.	*San Francisco*	23
Hanze, H. G.	*Solvang*	27
Hanzlik, P. J.	*San Francisco*	26
Happ, W. M.	*Beverly Hills*	10
Hara, H. J.	*Los Angeles*	10
Hara, M. F.	*Los Angeles*	10
Harada, M. A.	*Sacramento*	19
Harbaugh, O. S.	*San Diego*	22
Harbaugh, R. W.	*San Francisco*	23
Hardeman, V. V.	*San Francisco*	23
Harder, W. G.	*San Francisco*	23
Harder, W. R.	*Los Gatos*	28
Hardesty, J. T.	*Long Beach*	10
Harding, G. F.	*Santa Monica*	10
Harding, H. W.	*Oakland*	1
Harding, M. C.	*San Diego*	22
Harding, T. E. W.	*Los Angeles*	10
Harding, W. F.	*Point Reyes Station*	11
Hardy, B. W.	*Huntington Beach*	16
Hare, H. P.	*Los Angeles*	10
Hare, R. A.	*Takoma Park, Washington, D. C.*	27
Hargrove, G. K.	*Berkeley*	1
Harkness, J. T.	*Berkeley*	1
Harmon, E. D.	*San Francisco*	23
Harmon, R. E.	*Berkeley*	1
Harmon, R. J. P.	*Richmond*	3
Harmon, T. G.	*San Francisco*	23
Harner, C. E.	*Long Beach*	10
Harner, H. R.	*Los Angeles*	10
Harral, P.	*San Francisco*	23
Harrington, D. O.	*San Francisco*	23
Harrington, E. R.	*Los Angeles*	10
Harrington, J. T.	*Santa Cruz*	29
Harris, E. L.	*Oakland*	1
Harris, F. I.	*San Francisco*	23
Harris, G. F.	*Encinitas*	22
Harris, H. I.	*Los Angeles*	10
Harris, J. B.	*Sacramento*	19
Harris, J. M.	*Los Angeles*	10
Harris, M. S.	*Los Angeles*	10
Harris, M. W.	*Ross*	11
Harris, R. C.	*Santa Ana*	16
Harris, R. E.	*San Francisco*	23
Harris, W. A.	*Santa Ana*	16
Harrison, E.	*Los Angeles*	10
Harrison, W. H.	*San Francisco*	23
Harsh, G. F.	*San Diego*	22
Hart, A. C.	*Sacramento*	19
Hart, C. D.	*San Francisco*	23
Hart, D. E.	*Oakland*	1
Hart, H.	*Santa Barbara*	27
Hart, M. E.	*San Francisco*	26
Hart, M. G.	*Oakland*	1
Hart, S. D.	*Los Angeles*	10
Hart, V. W.	*Yreka*	31
Hart, W. E.	*Long Beach*	10
Hart, W. E.	*Oakland*	1
Harter, T. H.	*Pasadena*	10
Hartman, G. W.	*San Francisco*	23
Hartman, H.	*Modesto*	34
Hartman, M. M.	*San Francisco*	23
Hartman, R. B.	*Mill Valley*	11
Hartsough, C. W., Jr.	*Patton*	21
Hartwell, R. W.	*Beaumont*	18
Hartwig, C. H.	*San Francisco*	23
Hartwig, L. G.	*Los Angeles*	10
Haruff, J. J.	*Hollister*	20
Harvey, J. E.	*Pasadena*	10
Harvey, R. J.	*Anaheim*	16
Harwood, C. M.	*Santa Ana*	16
Harwood, D. A.	*Santa Ana*	16
Hashiba, G. K.	*Fresno*	4
Haskell, H. A.	*Santa Rosa*	33
Haskell, P. F.	*Artesia*	10
Hastings, H.	*Los Angeles*	10
Hastings, S. W.	*Monterey*	14
Hastreiter, R. F.	*Los Angeles*	10
Hatfield, H. L.	*Pasadena*	10
Havemann, M. S.	*Alameda*	1
Havenhill, A. D.	*Santa Cruz*	29
Hawes, R. E.	*Huntington Beach*	16
Hawk, C. L.	*Los Angeles*	10
Hawkins, C. L.	*Taft*	7
Hawkins, D. A.	*Los Angeles*	10
Hawkins, G. A.	*Reedley*	4
Hawkins, G. G.	*Madera*	4
Hawkins, H. M.	*Taft*	7
Hawkins, J. O.	*San Rafael*	11
Hawkins, L. P.	*Los Angeles*	10
Haworth, M. W.	*Sacramento*	19
Haworth, W. L.	*Los Angeles*	10
Hayden, C. T.	*San Francisco*	23
Hayden, W. C.	*Tulelake*	31
Hayes, C. M.	*Los Angeles*	10
Hayes, E. W.	*Monrovia*	10
Haygood, A. G.	*Downey*	10
Hayhurst, D. E.	*Ontario*	21
Hayhurst, J. S.	*Redlands*	21
Haymaker, W.	*San Francisco*	23
Haynes, F. W.	*Los Angeles*	10
Hayton, C. H.	*Los Angeles*	10
Hazel, J. K.	*San Francisco*	23
Hazeltine, M. E.	*San Rafael*	11
Heald, E. S.	*Berkeley*	1
Healey, E. F.	*San Francisco*	23

NAME	CITY	COUNTY SOCIETY NO.
Heard, W. R.	*Pasadena*	10
Hearn, T. M.	*Burbank*	10
Hebert, A. W.	*San Francisco*	23
Hedberg, C. C.	*San Francisco*	23
Heddens, V. O.	*Pasadena*	10
Hedges, L. A.	*Richmond*	3
Heegler, F. D.	*Napa*	15
Heffelfinger, M. A.	*Los Angeles*	10
Heidenreich, H. H.	*Los Angeles*	10
Heidenreich, W. M.	*Arcadia*	10
Heiges, L. E.	*Lompoc*	27
Hein, G. E.	*San Francisco*	23
Heinatz, M. A.	*Oakland*	1
Heinzman, W. H.	*San Francisco*	23
Heissig, I.	*Los Angeles*	10
Held, F.	*San Bernardino*	21
Helsley, G. F.	*San Francisco*	23
Helstrom, G. L.	*Fontana*	21
Hench, J. M.	*Stockton*	24
Henderson, A. M.	*Sacramento*	19
Henderson, C. W.	*Santa Barbara*	27
Henderson, E. W.	*Alameda*	1
Henderson, H. E.	*Santa Barbara*	27
Henderson, H. G.	*San Francisco*	23
Henderson, J. G.	*San Francisco*	23
Henderson, J. L.	*Compton*	10
Henderson, R. G.	*Long Beach*	10
Henderson, W. R.	*Long Beach*	10
Hendricks, F. R.	*Ventura*	37
Hendricks, M. D.	*Wasco*	7
Hendrickson, H. S.	*Los Angeles*	10
Henke, G. B.	*Ontario*	21
Hennessy, H. R.	*Bcrkeley*	21
Hennig, L. R.	*Willows*	38
Henning, B. H.	*San Francisco*	23
Henninger, L. L. R.	*Pasadena*	10
Henrich, A. G.	*Los Angeles*	10
Henriksen, E.	*Los Angeles*	10
Henry, A. W.	*San Leandro*	1
Henry, J. R.	*Oakland*	1
Henry, L. L.	*Pasadena*	10
Henry, M. G.	*Los Angeles*	10
Hensel, G. C.	*San Francisco*	23
Hensler, H. N.	*San Anselmo*	11
Hepp, V. E.	*Colusa*	38
Hepplewhite, J. G.	*Chico*	2
Heppner, G. J.	*San Francisco*	23
Heppner, M. J.	*San Francisco*	23
Herbert, W. R.	*San Diego*	22
Herman, B. S.	*San Francisco*	23
Herman, H. E.	*Corona*	18
Heron, I. C.	*San Francisco*	23
Herrick, A. B., Jr.	*Santa Rosa*	33
Herrick, F. L.	*Livermore*	1
Herring, J. B.	*San Francisco*	23
Herrington, E. L.	*San Francisco*	23
Herron, E. L.	*San Francisco*	23
Herscher, H. L.	*Los Angeles*	10
Hersh, J.	*Los Angeles*	10
Hershberger, L.	*Los Angeles*	10
Hershey, C. J.	*Los Angeles*	10
Hershman, F.	*Los Angeles*	10
Hertzog, F. C.	*Long Beach*	10
Herz, O.	*San Francisco*	23
Herzikoff, S. S.	*Los Angeles*	10
Herzog, G. K.	*San Francisco*	23
Herzog, G. K., Jr.	*San Francisco*	23
Hessel, V. E.	*Los Angeles*	10
Hessing, E. E.	*Oakland*	1
Heuler, L.	*Fellows*	7
Heuschele, W. H.	*San Jose*	28
Hewitt, D.	*Long Beach*	10
Hewitt, G. W.	*Los Angeles*	10
Heylmun, H. H.	*Long Beach*	10
Hiatt, R. S.	*Modesto*	34
Hiatt, T. M.	*Los Angeles*	10
Hibben, J. S.	*Pasadena*	10
Hickey, N. G.	*Walnut Park*	10
Hicks, A. M.	*San Francisco*	23
Hidy, K. W.	*Manteca*	24
Higbee, D. R.	*San Diego*	22
Higgs, D. W. P.	*Chula Vista*	22
Hilde, S. N.	*Riverside*	18
Hilgesen, J.	*Albany*	1
Hill, A. L.	*Los Angelcs*	10
Hill, E. J.	*Eureka*	5
Hill, E. W.	*San Andreas*	24
Hill, H. A.	*San Francisco*	23
Hill, H. G.	*Redlands*	21
Hill, H. P.	*San Francisco*	23
Hill, J. C.	*Palm Springs*	18
Hill, L. McK.	*Inglewood*	10
Hill, L. R.	*Long Beach*	10
Hill, M. R.	*Los Angeles*	10
Hill, R. B.	*Los Angeles*	10
Hill, R. C.	*Exeter*	36
Hill, T. P.	*Lakeport*	12
Hill, W. B.	*Long Beach*	10
Hiller, A. W.	*Long Beach*	10
Hilliard, C. G.	*Redlands*	21
Hills, C. B.	*Berkeley*	1
Hillyard, L. V.	*Los Angeles*	10
Hillyer, L.	*Los Banos*	13
Hilton, J. J.	*Los Angelcs*	10
Hilty, H. L.	*Los Angeles*	10
Hinckley, H. A.	*Hanford*	8
Hines, D. C.	*Palo Alto*	28
Hines, L. W.	*Santa Rosa*	33
Hinman, A. T.	*San Francisco*	23
Hinman, F.	*San Francisco*	23
Hipp, R. R.	*Santa Barbara*	27
Hippach, R. M.	*Los Angeles*	10
Hirsch, D. L.	*Grass Valley*	17
Hirschfeld, M. H.	*San Francisco*	23
Hirshfeld, S.	*Los Angeles*	10
Hiscox, E. J.	*Nuzvid, Kistna District, So. India*	21
Hitchcock, H. H.	*Oakland*	1
Hittlelman, J.	*Los Angeles*	10
Hixson, W. C., Jr.	*Beverly Hills*	10
Hoag, C. L.	*San Francisco*	23
Hoag, H. J.	*San Jose*	28
*Hobdy, W. C.	*San Francisco*	23
Hodgdon, F. W., Jr.	*Pasadena*	10
Hodges, F. T.	*San Francisco*	23
Hodges, W. A.	*La Vina*	10
Hodgin, R. I.	*Upland*	21
Hodgins, F. W.	*Oakland*	1
Hodgkin, P.	*El Centro*	6
Hoefer, A. G.	*San Diego*	22
Hoff, C. W.	*San Bernardino*	21
Hoffman, A. M.	*Los Angeles*	10
Hoffman, E. F.	*Los Angeles*	10
Hoffman, H. V.	*San Francisco*	23
Hoffman, L. H.	*San Francisco*	23
Hoffman, P. B.	*Marysville*	39
Hoffman, P. E.	*San Francisco*	23
Hoffman, R. L.	*San Diego*	22
Hoffman, R. O.	*San Diego*	22
Hogan, M. J.	*San Francisco*	22
Hogg, R. L.	*Saratoga*	28
Hohanshelt, A. S.	*Olive View*	10
Hohl, E. M.	*Los Angeles*	10
Hohnstein, F. I.	*Napa*	1
Hoilien, M. J.	*Eureka*	5
Hoke, P. I.	*Los Angeles*	10
Holbrook, E. F.	*San Francisco*	23
Holcomb, W. F.	*Oakland*	1
Holder, H. G.	*San Diego*	22
Holeman, G. S.	*Centerville*	1
Holko, J. E.	*San Francisco*	23
Holladay, F. S.	*Los Angeles*	10
Hollenbeck, A. E.	*Eagle Rock*	10
Holleran, W. M.	*Los Angeles*	10
Holley, W. W.	*Inglewood*	10
Holliger, C. D.	*Stockton*	24
Hollingsworth, J. B.	*Oakland*	1
Hollingsworth, L. D.	*Los Angcles*	10
Hollingsworth, M. W.	*Santa Ana*	16
Hollingsworth, P.	*Berkeley*	1
Hollombe, B. S.	*Los Angeles*	10
Holm, B. S.	*Quincy*	9
Holm, E.	*Eureka*	5
Holman, E. F.	*San Francisco*	23
Holman, W. F.	*Los Angeles*	10
Holmer, V. C.	*San Francisco*	23
Holmes, A. J.	*Pasadena*	10
Holmes, F.	*Beverly Hills*	10
Holmes, O. M.	*San Mateo*	26
Holt, C. Z.	*Los Angeles*	10
Holt, R. A., Jr.	*Los Angeles*	10
Holt, W. D.	*San Francisco*	2
Holzman, A. J.	*Santa Barbara*	27
Holzman, R. R.	*Los Angeles*	10
Hombach, F. J.	*Santa Barbara*	27
Homer, R. W.	*Ventura*	37
Homman, G. L.	*Long Beach*	10
Homme, O. H.	*Los Angeles*	10
Honaker, G. T.	*San Leandro*	1
Honda, R.	*Moneta*	10
Hoobler, H. R.	*Oakland*	1
Hooker, G. W.	*Lockeford*	24
Hooker, M. O.	*Santa Barbara*	27
Hooval, J. H.	*Ontario*	21
Hoover, E. F.	*San Diego*	22
Hoover, J. N.	*Long Beach*	10
Hope, R. B.	*Los Angeles*	10
Hopkins, E. K.	*San Francisco*	23
Hopkins, H.	*Los Angeles*	10
Hopkins, J. J.	*San Francisco*	23
Hopkins, J. W.	*Glendale*	10
Hopkins, M. A.	*Sacramento*	19
Hopkins, M. F.	*San Jose*	28
Hopkirk, C. C.	*Santa Monica*	10
Horner, C. D.	*San Francisco*	23
Horner, H. E.	*West Los Angeles*	10
Horner, W. D.	*San Francisco*	23
Horst, W. W.	*Wilmington*	10
Horton, F. L.	*Pomona*	10
Horwitz, M. J.	*Oakland*	1
Hosford, G. N.	*San Francisco*	23
Hoskins, G.	*Long Beach*	10
Hoskins, H. D.	*San Diego*	22
Hosmer, C. M.	*San Dicgo*	22
Hosmer, M. N.	*San Francisco*	23
Houck, G. H.	*Los Angeles*	10
Hough, R. C.	*San Diego*	22
*Houghton, A. D.	*San Fernando*	10
Houloose, J.	*Long Beach*	10
House, L. C.	*El Centro*	6
Houseworth, A. L.	*Los Angeles*	10
Houzvicka, O. A.	*San Diego*	22
*Hovde, A. G.	*Pasadena*	10
Howard, B. F.	*Sacramento*	19
Howard, C. E.	*San Diego*	22
Howard, G. R.	*Bell*	10
Howard, L. D., Jr.	*San Francisco*	23
Howard, N. J.	*San Francisco*	23
Howe, R. D.	*Redwood City*	26
Howell, A. J.	*Berkeley*	1
Howitt, H. O.	*San Rafael*	11
Howson, C. R.	*Los Angeles*	10
Hoyt, E. B.	*Spadra*	10
Hoyt, H. S.	*Pacific Grove*	14
Hoyt, W. F.	*Berkeley*	1
Hromadka, A. B.	*Santa Monica*	10
Hromadka, J. B.	*Santa Monica*	10
Hubbard, C. D.	*Huntington Park*	10
Hubbert, R. H.	*Arvin*	7
Hubert, C. I.	*Los Angeles*	10
Huenergardt, A. G.	*Los Angeles*	10
Huenergardt, H. A.	*Berkeley*	1
Huff, G. D.	*San Diego*	22
Huff, L. J.	*Los Angeles*	10
Huff, M. P.	*San Francisco*	22
Huffman, H. G.	*Santa Ana*	16
Huffman, L. D.	*Los Angeles*	10
Huggins, W. L.	*Los Angeles*	10
Hughes, E. G.	*Long Beach*	10
Hughes, R. E.	*Los Angeles*	10
Hughes, S. E.	*Tujunga*	10
Hull, E. H.	*San Bernardino*	21
Hull, J. F.	*Alhambra*	10
*Hull, J. P.	*Stockton*	24
Hull, R. L.	*Hollister*	20
Humber, J. D.	*San Francisco*	23
*Hummel, E. W.	*San Francisco*	12
Hummelt, B. W.	*Nevada City*	17
Humphrey, W. H.	*Oakland*	1
Humphreys, J. M.	*Sanger*	4
Hunnicutt, C. C.	*Montebello*	10
Hunnicutt, L. G.	*Pasadena*	10
Hunsberger, H. S.	*San Francisco*	23
Hund, H. O.	*San Rafael*	11
Hunt, C. E.	*Piedmont*	1
Hunt, R. A.	*Riverdale*	4
Hunt, V. C.	*Los Angeles*	10
Hunt, W. A.	*Fresno*	4
Hunt, W. R.	*Santa Barbara*	27
Hunter, P. M.	*Pasadena*	10
Hunter, T. V.	*Hollywood*	10
Hunter, W. E.	*Los Angeles*	10
Hunter, W. E.	*Los Angeles*	10
Huntington, B. R.	*Los Angeles*	10
Huntington, H. A.	*Los Angeles*	10
Huntley, A. C.	*Point Arena*	12
Hurd, A. H.	*Pasadena*	10
Hurwitt, S. J.	*San Francisco*	23
Hurwitz, S.	*San Francisco*	23
Hurwitz, S. H.	*San Francisco*	23
Husband, R. D.	*Modesto*	34
Huston, J. M.	*Burlingame*	26
Hutchings, R. K.	*San Francisco*	23
Hutchinson, W. W.	*Los Angeles*	10
Hutchison, C. W.	*Los Angeles*	10
Hyatt, H. W.	*Eldridge*	33
Hyde, R. D.	*Beverly Hills*	10
Hyland, C. M.	*Los Angeles*	10
Hyman, E.	*Los Angeles*	10
— I —		
Ianne, C. L.	*San Jose*	28
Iki, G. S.	*Sacramento*	19
Illick, C. R.	*Santa Paula*	37
Ilsley, M. L.	*Claremont*	10
Imerman, C. P.	*Hollywood*	10
Imerman, S. W.	*Hollywood*	10
Imler, H. G.	*Los Angeles*	10
Ing, C. S.	*Stockton*	24
Ingalls, A. T.	*Los Angeles*	10
Ingber, I. S.	*San Francisco*	23
Ingels, A. E.	*San Francisco*	23
Ingham, S. D.	*Los Angeles*	10
Inghram, H. D.	*San Bernardino*	21
Ingram, C. H.	*Fresno*	4
Inman, J. H.	*Bakcrsfield*	7
Inman, M. M.	*Los Angeles*	10
Inman, T. G.	*San Francisco*	23
Innis, E. C.	*Newhall*	10
Iriki, W. K.	*Oakland*	1
Irish, C. W.	*Los Angeles*	10
Irvin, C. E.	*Anaheim*	16
Irvine, A. R.	*Los Angeles*	10
Irvine, G. S.	*Oakland*	1
Irvine, R. S.	*San Francisco*	23
Irvinc, S. R.	*Los Angeles*	10
Irwin, J. C.	*Los Angcles*	10
Isaac, J. P.	*Glendale*	10
Ishikawa, T.	*San Jose*	28
Isnardi, M.	*San Francisco*	23
Isoard, M. C.	*Sacramento*	19
Ito, P. K.	*Los Angcles*	10
Ivey, E. D.	*Oakland*	1
— J —		
Jackemy, E. J.	*Oakland*	1
Jackson, E. A.	*Atwater*	13
Jackson, J. E.	*Los Angeles*	10
Jackson, L. H.	*W. Los Angeles*	10
Jacob, H. H.	*Long Beach*	10
Jacobs, A. M.	*San Francisco*	23
Jacobs, F. E.	*San Diego*	22

NAME	CITY	COUNTY SOCIETY NO.
Jacobs, J.	*Los Angeles*	10
Jacobs, J.	*San Francisco*	23
Jacobs, L. C.	*San Francisco*	23
Jacobs, M. L.	*Los Angeles*	10
Jacobs, S. N.	*San Francisco*	23
Jacobsen, J. F.	*San Francisco*	23
Jacobson, H. A.	*Fresno*	4
Jacobson, H. P.	*Los Angeles*	10
Jacobson, P. N.	*Oakland*	1
Jacobus, L. R.	*Berkeley*	1
Jacoby, L. A.	*Oroville*	2
Jaekle, R. F.	*San Francisco*	23
Jamentz, S. K.	*Los Angeles*	10
James, C. A.	*Fresno*	4
James, C. M.	*Beverly Hills*	10
James, C. S.	*Los Angeles*	10
James, L.	*Fresno*	4
James, M.	*San Francisco*	23
James, R. J.	*Los Angeles*	10
James, V. M.	*Hollywood*	10
Jameson, P. V.	*Huntington Park*	10
Jankay, L.	*San Bernardino*	27
Janzen, J.	*Loma Linda*	21
Jeancon, E. C.	*Los Angeles*	10
Jeffry, D. E.	*Oakland*	1
Jeffs, M. D. W.	*Los Angeles*	10
Jelinek, J. J.	*Los Angeles*	10
Jellen, J.	*Los Angeles*	10
Jelte, S. A.	*Oakland*	1
Jenkins, B. E.	*Oakland*	1
Jenkins, H. L.	*Arcata*	5
Jenkins, K. B.	*Oakland*	1
Jenkins, R. B.	*Los Angeles*	10
Jenney, E. R.	*Los Angeles*	10
Jenney, W. C.	*Vacaville*	32
Jennison, J. E.	*San Diego*	22
Jensen, O. B.	*Livermore*	1
Jeong, B. Y.	*San Francisco*	23
Jesberg, S.	*Los Angeles*	10
Jetton, J. A.	*Fallbrook*	22
Jewel, R. T.	*Los Angeles*	10
Jewett, R. A.	*Los Angeles*	10
Jimerson, J. R.	*Long Beach*	10
Johanson, V. E.	*San Francisco*	23
Johnsen, K.	*Agnew*	28
Johnson, C. E.	*Long Beach*	10
Johnson, C. F.	*Oakland*	1
Johnson, C. G.	*Long Beach*	10
Johnson, C. M.	*San Francisco*	23
Johnson, C. R.	*Whittier*	10
Johnson, D. D.	*Grass Valley*	17
Johnson, E. D. L.	*Alhambra*	10
Johnson, E. E.	*Palo Alto*	28
Johnson, F. T.	*Monrovia*	10
Johnson, G. H.	*Los Angeles*	10
Johnson, G. M.	*Los Angeles*	10
Johnson, G. S.	*San Francisco*	23
Johnson, H. H.	*San Francisco*	23
Johnson, H. M.	*Pasadena*	10
Johnson, H. R.	*Sacramento*	19
Johnson, H. S.	*Long Beach*	10
Johnson, H. S.	*Los Angeles*	10
Johnson, J. D.	*Taft*	7
Johnson, J. K.	*Culver City*	10
Johnson, L. C.	*Salinas*	14
Johnson, M.	*Los Angeles*	10
Johnson, M. L.	*Oakland*	1
Johnson, N. P.	*Stockton*	24
Johnson, O. D.	*Los Angeles*	10
Johnson, O. F.	*Sacramento*	19
Johnson, P.	*San Francisco*	23
Johnson, R.	*Compton*	10
Johnson, R. H.	*Los Angeles*	10
Johnson, R. I.	*Westminster*	16
Johnson, R. L.	*Corona*	18
Johnson, R. W.	*San Fernando*	10
Johnson, S. P.	*Los Angeles*	10
Johnson, T.	*Porterville*	36
Johnson, W. A.	*Antioch*	3
Johnson, W. C.	*Pomona*	10
Johnson, W. C.	*Salinas*	14
Johnson, W. T.	*Alhambra*	10
Johnston, E. J.	*South Pasadena*	10
Johnston, F. R.	*Oakland*	1
Johnston, H. A.	*Anaheim*	16
Johnston, J.	*Los Angeles*	10
Johnston, S. T.	*Battle Creek, Mich.*	22
Johnston, W. H.	*Santa Barbara*	27
Johnstone, G. A.	*Los Angeles*	10
Johnstone, E. M.	*Pasadena*	10
Johnstone, K. B.	*Imola*	15
Johnstone, R. T.	*Los Angeles*	10
Johnstone, W. A.	*Hanford*	8
Jones, A. A.	*Long Beach*	10
Jones, C. P.	*Grass Valley*	17
Jones, C. R.	*San Diego*	22
Jones, E. W.	*Pasadena*	10
Jones, E. W.	*Los Angeles*	10
Jones, F. B.	*Vallejo*	32
Jones, G. F.	*San Francisco*	23
Jones, G. W.	*Los Angeles*	10
Jones, H. T.	*Los Angeles*	10
Jones, H. W.	*Bakersfield*	7
Jones, I. H.	*Los Angeles*	10
Jones, I. W.	*Los Angeles*	10
Jones, J. C.	*Los Angeles*	10
Jones, J. P.	*Los Angeles*	10
Jones, J. R.	*Sacramento*	19
Jones, J. W.	*San Francisco*	23
Jones, K. P.	*Waikoa, Maui, T. H.*	10
Jones, L.	*Alhambra*	10
Jones, L. E.	*Roseville*	17
Jones, L. L.	*Glendale*	10
Jones, N.	*Los Angeles*	10
Jones, N.	*Sacramento*	19
Jones, O. C.	*Santa Maria*	27
Jones, O. W.	*San Anselmo*	11
Jones, O. W., Jr.	*San Francisco*	23
Jones, R. A.	*San Francisco*	23
Jones, R. B.	*San Francisco*	23
Jones, R. W.	*Yreka*	31
Jones, S. C.	*San Francisco*	23
*Jones, W. A.	*Riverside*	18
Jones, W. H.	*Long Beach*	10
Jones, W. H. G.	*Los Gatos*	28
Jordan, P. A.	*San Jose*	28
Jorgensen, S. N.	*San Francisco*	23
Jorgenson, N.	*Fresno*	4
Josephs, I. L.	*Los Angeles*	10
Josephs, L.	*Los Angeles*	10
Josephson, J. B.	*San Jose*	28
Joyce, T. F.	*Spadra*	10
Judd, G. E.	*Los Angeles*	10
Judefind, T. F.	*Loma Linda*	21
Judge, W. D.	*Los Angeles*	10
Judson, H. A.	*Brentwood Heights*	10
Juenemann, G. F.	*Los Angeles*	10
Jumblatt, A.	*Pacific Beach*	22
Jump, K.	*San Mateo*	26
— K —		
Kaelber, A. P.	*San Francisco*	23
Kaffesieder, L. I.	*Los Angeles*	10
Kaftan, L. L.	*Los Angeles*	10
Kahl, C. W.	*Incline*	13
Kahler, A. R.	*Sacramento*	19
Kahn, H.	*Santa Maria*	27
Kahn, J.	*Los Angeles*	10
Kahn, M. G.	*Los Angeles*	10
Kalfus, J. L.	*Santa Maria*	27
Kalichman, G. S.	*Santa Monica*	10
Kanagawa, H. H.	*Stockton*	24
Kane, L. M.	*Los Angeles*	10
Kanner, H. M.	*Sacramento*	19
Kaplan, H. E.	*Brookline, Mass.*	24
Kaplan, M.	*Los Angeles*	10
Kapp, M. W.	*San Jose*	28
Karfiol, G. J.	*San Francisco*	23
Karleen, P. E.	*Soquel*	29
Karo, H. L.	*Grass Valley*	17
Karr, M.	*Sonora*	24
Karras, R. W.	*Dwight, Ill.*	10
Karshner, R. G.	*Los Angeles*	10
Katz, B.	*Los Angeles*	10
Kaufman, B.	*San Francisco*	23
Kavanagh, M. F.	*San Francisco*	23
Kavinoky, N. R.	*Los Angeles*	10
Kay, G. L.	*Redding*	30
Kay, J. H.	*Oakland*	1
Kay, M. M.	*Shafter*	7
Kay, R.	*Los Angeles*	10
Kay, W. E., Jr.	*San Francisco*	23
Kaysen, R.	*San Diego*	22
Kearney, F. K.	*Hayward*	1
Kearney, W. B.	*San Francisco*	23
Keating, V. J.	*Los Angeles*	10
Keeler, N. S.	*Oakland*	1
Keenan, A. S.	*San Francisco*	23
Keeney, M. J.	*Los Angeles*	10
Kegel, A. H.	*Los Angeles*	10
Keiper, G. F.	*Beverly Hills*	10
Keipp, J. V.	*Long Beach*	10
Keith, C. F.	*Williams*	38
Kelker, G. D.	*San Luis Obispo*	25
Kell, F. B.	*San Bernardino*	21
Keller, F.	*Los Angeles*	10
Keller, S. H.	*Riverside*	18
Kelley, E. H.	*San Diego*	22
Kelley, H. W.	*Oakland*	1
Kelley, J. W.	*Los Angeles*	10
Kellogg, E. C.	*Los Angeles*	10
Kellogg, F.	*Long Beach*	10
Kellogg, J. O.	*San Diego*	22
Kellogg, K. E.	*Loma Linda*	21
Kelly, A. L.	*Oceanside*	22
Kelly, T. H.	*San Francisco*	23
Kelsey, T. W.	*Sacramento*	19
Kelso, G. C.	*Pittsburg*	3
Kelso, R. W.	*Long Beach*	10
Keltz, C.	*Los Angeles*	10
Kemp, D. H.	*San Francisco*	23
Kemper, C. A. S.	*Escondido*	22
Kennedy, C. R.	*Paso Robles*	25
Kennedy, K. E.	*Oakland*	1
Kennedy, W. J.	*Oakland*	1
Kennell, L. A.	*San Diego*	22
Kenney, E. W.	*Oakland*	1
Kennicott, R. H.	*Los Angeles*	10
Kerchner, R. R.	*Montebello*	10
Kerlan, M.	*Beverly Hills*	10
Kerns, C. L.	*Pittsburg*	3
Kerr, W. J.	*San Francisco*	23
Kersten, E. H. W.	*Anaheim*	16
Kersten, H. M.	*Los Angeles*	10
Keser, M. D.	*Richmond*	3
Kesling, E. F.	*Los Angeles*	21
Kessler, E. E.	*Los Angeles*	10
Key, W. A.	*San Mateo*	26
Keye, J. D.	*Beverly Hills*	10
Keyes, H. R.	*Los Angeles*	10
Kibbe, M. E.	*Oakland*	1
Kibby, S. V.	*Los Angeles*	10
Kidder, F. W. K.	*Los Angeles*	10
Kiger, W. H.	*Los Angeles*	10
Kilbourne, E. D.	*Los Gatos*	28
*Kilbourne, N. J.	*Los Angeles*	10
Kilcher, C. W.	*Sacramento*	19
Kilduff, R.	*Oroville*	2
Kile, R. F.	*San Francisco*	23
Kilfoy, E. J.	*Los Angeles*	10
Kilgariff, K.	*Stanford University*	28
Kilgore, A. M.	*Hollywood*	10
Kilgore, A. R.	*San Francisco*	23
Kilgore, E. S.	*San Francisco*	23
Kilgore, G. L.	*San Diego*	22
Kimball, T. S.	*Glendale*	10
Kimberlin, L. O.	*San Francisco*	23
Kinard, K. W.	*La Jolla*	22
Kindall, C. E.	*Los Angeles*	10
Kindall, L. E.	*Oakland*	1
Kindopp, D. M.	*Auburn*	17
King, C. S.	*Hollywood*	10
King, D. E.	*San Francisco*	23
King, E. B.	*Arroyo Grande*	25
King, E. H.	*Tujunga*	10
King, J. A.	*Ojai*	37
King, J. C. E.	*San Diego*	22
*King, J. M.	*Los Angeles*	10
King, N. C.	*Los Angeles*	10
King, R. W.	*Los Angeles*	10
King, R. W.	*San Jose*	28
King, W.	*Chico*	2
Kinkade, J. M.	*Inglewood*	10
Kinney, J. G.	*Santa Monica*	10
Kinney, L. C.	*San Diego*	22
Kinney, M. A. J.	*Los Angeles*	10
Kinslow, F. A.	*San Francisco*	23
Kinzer, E. E.	*South Pasadena*	10
Kirchner, A. A.	*Los Angeles*	10
Kirchner, H. J.	*Los Angeles*	10
Kirchoff, J. J.	*Los Angeles*	10
Kirk, A. W.	*San Francisco*	23
Kirk, J. H.	*Palo Alto*	28
Kirk, M. E.	*Oakland*	1
Kirkle, O. L.	*Napa*	15
Kirkpatrick, J. E.	*Redding*	10
Kirkpatrick, J. H.	*Los Angeles*	10
Kirsch, R. L.	*Pasadena*	10
Kirsten, E. L.	*Los Angeles*	10
Kirwin, J. J.	*Ukiah*	12
Kiser, A. E.	*Imola*	15
Kiskadden, W. S.	*Los Angeles*	10
Kistinger, W. F.	*Santa Ana*	16
Kistler, J. E.	*San Francisco*	23
Kistler, R. H.	*San Francisco*	23
Kitagawa, K. J.	*San Francisco*	23
Kittle, D. B.	*Napa*	15
Kittridge, E. McN.	*Los Angeles*	10
Kjaerbye, C. P. H.	*Fresno*	4
Klabunde, E. H.	*San Francisco*	23
Kleeman, G. E., Jr.	*Oakland*	1
Klein, I.	*Los Angeles*	10
Klick, J. J.	*Sacramento*	19
Kliman, F. E.	*Los Angeles*	10
Kling, D. H.	*Los Angeles*	10
Klotz, N. C.	*San Francisco*	23
Kluss, E. R.	*Santa Barbara*	27
Klussman, H. O. G. T.	*San Francisco*	23
Knapp, E. V.	*San Anselmo*	11
Kneeshaw, R. S.	*San Jose*	28
Knight, L. C.	*San Francisco*	23
Knoll, R. F.	*Los Angeles*	10
Knopf, B. W.	*Oakland*	1
Knorp, W. F.	*Burlingame*	26
Knorr, L. R.	*Concord*	3
Knox, C. R.	*El Cajon*	22
Knox, L. M.	*Berkeley*	1
Knox, S. C.	*Los Angeles*	10
Koch, P. L.	*Sacramento*	19
Kocher, R. A.	*Carmel*	14
Koda, K.	*Watsonville*	29
Koebig, W. C. S.	*Los Angeles*	10
Koefod, H. O.	*Santa Barbara*	27
Koehler, A. E.	*Santa Barbara*	27
Koenecke, H. J.	*Salinas*	14
Koepke, F. H.	*Watsonville*	29
Koerber, G. E.	*Oakland*	1
Koford, H.	*Oakland*	1
Kohlenberger, C. F. W.	*Fullerton*	16
Kohlhase, L. H.	*Los Angeles*	10
Kohls, C. L.	*San Francisco*	23
Kohn, F.	*Tulare*	36
Kolb, H. J.	*Oakland*	1
Kolda, F. O.	*Alhambra*	10
Kolisch, J. M.	*Los Angeles*	10
Konantz, O. F.	*Hollywood*	10
Konigmacher, A. H.	*Fresno*	4
Konigsberg, J.	*San Francisco*	23
Konttas, P. V.	*Baltimore, Md.*	33
Koplin, H.	*Los Angeles*	10
Kopelowitz, J. C.	*Los Angeles*	10
Korshet, M.	*San Francisco*	23

NAME	CITY	COUNTY SOCIETY NO.
Kortheuer, K. H.	*Calexico*	6
Kosky, A. A.	*Santa Monica*	10
Kosky, A. W.	*Santa Monica*	10
Kosterlitz, E.	*Berkeley*	1
Kracaw, F. C.	*Oakland*	1
Kraft, R. W.	*Altadena*	10
Krahulik, E. J.	*Hollywood*	10
Kramar, L. G.	*Fortuna*	5
Kraushaar, I. N.	*La Habra*	16
Kraushaar, J. C.	*Garden Grove*	16
Kreinman, S. G.	*Los Angeles*	10
Kremers, E. D.	*Pasadena*	10
Kremers, M. Y.	*Pasadena*	10
Kress, G. H.	*Los Angeles*	10
Kretzschmar, K. E.	*Los Angeles*	10
Kristensen, W. A.	*Los Angeles*	10
Kreutzmann, H. A. R.	*San Francisco*	23
Krevitt, J. M.	*Oildale*	7
Kroener, W. F.	*Whittier*	10
Kroger, W. P.	*Los Angeles*	10
Krohn, H. N.	*Los Angeles*	10
Krohn, L.	*Los Angeles*	10
Kroll, F. W.	*San Francisco*	23
Krout, B. M.	*Stockton*	24
Krueger, A. P.	*Berkeley*	1
Krugmeier, C. E.	*Los Angeles*	10
Krull, F.	*Sacramento*	19
Kruse, F. H.	*San Francisco*	23
Kruse, F. L.	*San Francisco*	23
Krutchkoff, M.	*Ferndale*	5
Kryder, G. B.	*Glendale*	10
Kuder, W. S.	*Oakland*	1
Kuhlmann, F. W.	*Long Beach*	10
Kuhn, O. E.	*Inglewood*	24
Kulaev, A. A. M.	*San Francisco*	23
Kulchar, G. V.	*San Francisco*	23
Kully, B. M.	*Los Angeles*	10
Kupka, E.	*Olive View*	10
Kusel, E. A.	*Oroville*	2
Kutzmann, A. A.	*Los Angeles*	10
Kyddson, T. W.	*Linden*	24

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NAME	CITY	COUNTY SOCIETY NO.
Lacayo, J. R.	*Los Angeles*	10
Lacey, J. M.	*Los Angeles*	10
Lacey, L. E.	*Oakland*	1
Lacey, M. J.	*Albany*	1
Lachman, G. S.	*San Francisco*	23
Lackner, L.	*San Jose*	28
Lacoe, J. R.	*Los Angeles*	10
Lafontaine, E. C.	*San Francisco*	23
Lagen, J. B.	*Burlingame*	26
Laing, D. R.	*Pasadena*	10
Laist, O.	*San Francisco*	23
Lajoie, R. J.	*Los Angeles*	10
Lake, T. O.	*Berkeley*	1
Lakey, W. J.	*Canoga Park*	10
Lamb, E. J.	*Santa Barbara*	27
Lamb, L. M.	*Oakland*	1
Lamb, P. V.	*Angels Camp*	24
Lamb, W. K.	*Berkeley*	1
Lambert, H. W.	*Berkeley*	1
Lambertson, E. R.	*Los Angeles*	10
Lambuth, R. W.	*Santa Barbara*	27
La Mont, W.	*Beverly Hills*	10
Lamson, R. W.	*Los Angeles*	10
*Lancaster, J. S.	*Torrance*	10
Landegger, G. P.	*Los Angeles*	10
Landers, C. H.	*Los Angeles*	10
Landis, C. C.	*Chico*	2
*Lando, M. E.	*Oakland*	1
Landon, G. S.	*San Bernardino*	21
Landrock, G. M.	*Sausalito*	11
Lane, C. R.	*Santa Monica*	10
Lane, C. W.	*Coronado*	22
Lane, E. H.	*Los Angeles*	10
Lane, J. A.	*Eureka*	5
Lang, J. H.	*Fullerton*	16
Langan, A. J.	*San Pedro*	10
Langdon, E. E.	*Santa Monica*	10
*Langdon, S. W. R.	*Stockton*	24
Lange, H. W.	*Bakersfield*	8
Langer, J.	*San Bernardino*	21
Langley, R. W.	*Los Angeles*	10
Langlois, L. J.	*San Diego*	22
Langstroth, L.	*San Francisco*	23
Lanphere, G. H.	*Los Angeles*	10
Larkey, J.	*Oakland*	1
Larsen, A. E.	*San Francisco*	23
Larsen, E.	*Los Angeles*	10
Larsen, J. W.	*Philadelphia, Pa.*	25
Larson, A. H.	*Los Angeles*	10
Larson, C. F.	*Sausalito*	11
Larson, E. A.	*Kingsburg*	4
Larson, E. E.	*Los Angeles*	10
Larson, J. A.	*Anaheim*	16
Larsson, E.	*Beverly Hills*	10
Lartigau, A. J.	*San Francisco*	23
Laton, G. P.	*Los Angeles*	10
Laubersheimer, A.	*Los Angeles*	10
Laubersheimer, G. A.	*Los Angeles*	10
Lauder, C. H.	*Los Angeles*	10
Lauer, C. A.	*Long Beach*	10
Laughlin, T. J.	*Hollywood*	10
Lavery, W. A.	*Loyalton*	17
Laverty, L. F.	*San Clemente*	16
Lavine, B.	*Los Angeles*	10

NAME	CITY	COUNTY SOCIETY NO.
Lawler, P. W.	*Victorville*	21
Lawler, T. G.	*San Francisco*	23
Lawler, W. H.	*Salinas*	14
Lawrence, L. B.	*Oakland*	1
Lawrence, N. B.	*Colton*	21
Lawrence, W.	*San Francisco*	23
Lawson, J. D.	*Sacramento*	19
Lawson, T. C.	*Oakland*	1
Lawyer, P. C.	*Inglewood*	10
Layman, M. H.	*San Francisco*	23
Lazar, S.	*San Francisco*	23
Lazard, E. M.	*Los Angeles*	10
Lazelle, H. G.	*La Jolla*	22
Leach, C. W.	*San Francisco*	23
Leach, W. O.	*Glendale*	10
Leachman, R. S.	*Vallejo*	32
Leake, N. A.	*Torrance*	10
Leake, W. H.	*Los Angeles*	10
Leavenworth, E. C. S.	*Brentwood*	24
Leavitt, A. S.	*Los Angeles*	10
Leavitt, F. J.	*Los Angeles*	10
Le Baron, R. O.	*Talmage*	12
Ledesma, S. B.	*Salinas*	10
Ledford, R. M.	*San Diego*	22
Ledyard, C. C.	*Los Angeles*	10
Lee, D.	*San Jose*	28
Lee, D. A.	*Boston, Mass.*	24
Lee, E. C.	*San Diego*	22
Lee, F. J.	*Santa Monica*	10
Lee, F. W.	*Sacramento*	19
Lee, H.	*San Jose*	28
Lee, L. D.	*Glendale*	10
Lee, L. H.	*Los Angeles*	10
Lee, R. V. A.	*Palo Alto*	28
Leef, E.	*San Francisco*	23
Leet, N. B.	*Oakland*	1
Leet, R. S.	*Oakland*	1
Leete, C. M.	*Pasadena*	10
Leffingwell, F. E.	*Montebello*	10
Lefler, A. B.	*Los Angeles*	10
Leftwich, O. T.	*Oakland*	1
Legge, R. F.	*Oakland*	1
Legge, R. T.	*Berkeley*	1
Leggitt, C. M.	*Compton*	10
Leggitt, R. C.	*Glendale*	10
Leggo, R. C.	*Crockett*	3
Leidig, L. R.	*Santa Monica*	10
Leimbach, J. H.	*Isleton*	18
Leiske, S. W.	*Lodi*	24
Leland, E. B.	*Oakland*	1
Leland, H. G.	*Klamath*	5
Leland, S.	*San Francisco*	23
Lemere, H. B.	*Beverly Hills*	10
Lennon, M. B.	*San Francisco*	23
Lennon, T. J.	*San Francisco*	23
Leon, T. D.	*Concord*	3
Leonard, A. T.	*San Francisco*	23
Leonard, C. D.	*San Jose*	28
Leonard, E. M.	*San Francisco*	23
Leonard, J. V.	*San Francisco*	23
Leonard, W. E.	*Los Angeles*	10
*Lepper, L. E.	*Los Angeles*	10
Lerned, M. B.	*Pasadena*	10
Lesen, A. M.	*San Diego*	22
Lesser, R. P.	*Oakland*	1
Leuschner, C. E.	*Los Angeles*	10
Leveton, A. L.	*San Francisco*	23
Levin, E.	*Los Angeles*	10
Levin, E. A.	*San Francisco*	23
Levin, H. A.	*Los Angeles*	10
Levin, H. G.	*Westwood*	9
Levin, L. M.	*Pasadena*	10
Levin, M. A.	*Los Angeles*	10
Levin, W. N.	*Avenal*	7
Levine, P.	*Los Angeles*	10
Levitin, J.	*Sausalito*	23
Leviton, H. I.	*Los Angeles*	10
Levy, E. I.	*San Diego*	23
Levy, J. J.	*Los Angeles*	4
Levy, M. L.	*Los Angeles*	10
Lewe, G. H.	*Los Angeles*	10
Lewin, R.	*Oakland*	1
Lewis, C. E.	*Auburn*	17
Lewis, C. H.	*Pacific Palisades*	10
Lewis, F. D.	*Oakland*	1
Lewis, J. D.	*Santa Barbara*	27
Lewis, K.	*Beverly Hills*	10
Lewis, L. R.	*Los Angeles*	10
Lewis, M. L.	*Petaluma*	33
Lewis, N. H.	*Hollywood*	10
Lewis, S. A.	*Hollywood*	10
Lewis, W. M.	*San Diego*	22
Libby, A. A.	*Pasadena*	10
Lighthill, J. A.	*Shafter*	7
Lien, F. O.	*Merced*	13
Liles, L. M.	*Watsonville*	29
Liliencrantz, G. H.	*Oakland*	1
Liljedahl, E. N.	*Los Angeles*	10
Liljencrantz, E.	*San Francisco*	23
Lilley, W. E.	*Merced*	13
Linde, F. G.	*San Francisco*	23
Lindemulder, F. G.	*San Diego*	22
Lindenberg, F.	*Los Angeles*	10
Lindner, H. H.	*San Francisco*	23
Lindquist, C. A.	*Los Angeles*	10
Lindquist, E. N.	*Culver City*	10
Lindroth, E.	*Long Beach*	10
Lindsay, C. V.	*Encinitas*	22

NAME	CITY	COUNTY SOCIETY NO.
Lindsay, H. C. L.	*Hollywood*	10
Lindsey, J. O.	*Santa Monica*	10
Lindsley, St. C. R.	*Los Angeles*	10
Lindstrum, J. W.	*Marysville*	39
Lineer, A. S.	*Los Angeles*	10
Linhart, L. R.	*Los Angeles*	10
Linn, J. L.	*Glendale*	10
Linn, J. R.	*Biggs*	2
Linsley, C. H.	*Los Angeles*	10
Linthicum, F. H.	*Los Angeles*	10
Lion, E. G.	*San Francisco*	23
Lipe, J. T.	*La Jolla*	22
Lipkis, A.	*Los Angeles*	10
Lipman, M. P.	*Los Angeles*	10
Lipp, M. J.	*Sacramento*	19
Lippman, M. H.	*San Francisco*	23
Lipsett, E. M.	*San Francisco*	23
Lipsett, P. J.	*Oakland*	1
Lipson, B.	*Los Angeles*	10
Lipson, I. M.	*Visalia*	36
Lischner, H.	*Los Angeles*	10
Lisser, H.	*San Francisco*	23
Lissner, H. H.	*Los Angeles*	10
Lista, L. J.	*Mt. Shasta*	31
Liston, E.	*Palo Alto*	28
Litchfield, H.	*Los Angeles*	10
Litle, E. W.	*Los Angeles*	10
Little, R. P.	*Santa Paula*	37
Lloyd, J. H.	*Fort Bragg*	12
Lloyd, O. D.	*Los Angeles*	10
Lloyd-Jones, O.	*Los Angeles*	10
Lockwood, M. S.	*National City*	22
Lodge, E. S.	*Los Angeles*	16
Loe, H. D.	*Oakland*	1
*Loehr, B. E.	*San Jose*	28
Logan, N. H.	*Oakland*	1
Logsdon, R. O.	*San Diego*	22
Lohlein, H. E.	*Reno, Nevada*	33
Lohmann, H. G.	*Oakland*	1
Lohnberg, E.	*San Francisco*	23
Lohse, J. L.	*Oakland*	1
Loizeaux, E. S.	*San Diego*	22
Lokrantz, S. R.	*Los Angeles*	10
Lomas, J. B.	*Los Angeles*	10
Lomas, M. I.	*Los Angeles*	10
Lonergan, L.	*Loma Linda*	21
Long, F. E.	*Los Angeles*	10
Long, H. E.	*Berkeley*	1
Long, J. C.	*Hemet*	18
Longnecker, L. P.	*Eldridge*	33
Loomis, F. M.	*Oakland*	1
Loomis, N. M.	*Yuba City*	39
Loos, H. C.	*Los Angeles*	10
Looser, R. V.	*Hollywood*	10
Lopez, C. J.	*Hollywood*	10
*Lopez, E. A.	*San Leandro*	1
Lopizich, I. J.	*Los Angeles*	10
Lord, D. C.	*Paradise*	2
Lordan, J. P.	*Los Angeles*	10
Lorentz, R., Jr.	*San Francisco*	23
Lorenz, H. E.	*Sacramento*	19
Loring, F. W.	*Glendale*	10
Loughlin, E. L.	*Los Angeles*	10
Lounsberry, C. R.	*San Diego*	22
Loutzenheiser, J. J.	*San Francisco*	23
Love, A. A.	*Los Angeles*	10
Love, C. A., Jr.	*San Bernardino*	21
Love, E. C.	*Calistoga*	15
Lovejoy, E. D.	*Los Angeles*	10
Lovell, H. O.	*Jackson*	19
Lovely, J. P.	*San Jose*	28
Loven, S. M.	*Bakersfield*	7
*Loveren, G. S.	*Santa Barbara*	27
Low, T. C.	*Los Angeles*	10
Lowe, F. A.	*San Francisco*	23
Lowe, W. F.	*Jackson*	19
Lowell, G. C.	*San Anselmo*	11
Lowman, C. L. R.	*Los Angeles*	10
Loye, G.	*San Francisco*	12
Lubin, M. L.	*San Francisco*	23
Lucas, W.	*Los Angeles*	10
Lucas, W. P.	*San Francisco*	23
Lucas, W. S.	*Richmond*	3
Lucey, D. D.	*Los Angeles*	10
Lucia, S. P.	*San Francisco*	23
Luckie, J. B.	*Pasadena*	10
Ludwig, J. L.	*Los Angeles*	10
Luechauer, K. D.	*Fresno*	4
Lum, D. D.	*Alameda*	4
Lumley, C. G.	*Huntington Park*	10
Lumsden, A. G.	*Petaluma*	33
Lund, C. E.	*No. Hollywood*	10
Lund, Le V.	*Los Angeles*	10
Lundegaard, E. E.	*Colfax*	17
Lundegaard, E. M.	*Oakland*	1
Lundquist, D. T.	*Palo Alto*	28
Lunsford, C. J.	*Oakland*	1
Lupton, E. L.	*Los Angeles*	10
Lurie, S. A.	*Los Angeles*	10
Lusignan, H. R.	*Monterey*	14
Luton, G. R.	*Santa Barbara*	27
Lyle, A. G.	*San Francisco*	23
Lyman, E. W.	*Berkeley*	1
Lyman, G. D.	*San Francisco*	23
Lyman, T.	*Sacramento*	19
Lynch, D.	*Omaha, Nebraska*	10
Lynch, F. W.	*San Francisco*	23
Lynch, W. C.	*Daly City*	26

NAME	CITY	COUNTY SOCIETY NO.
Lynch, W. P.,	*Stockton*	24
Lyon, T. P.,	*Gilroy*	28
Lyster, R. W.,	*Los Angeles*	10

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NAME	CITY	COUNTY SOCIETY NO.
Macauley, J.,	*Los Angeles*	10
MacColl, D. R.,	*Los Angeles*	10
MacCoy, E. L.,	*Fontana*	37
Macdonald, C. A.,	*Barstow*	21
MacDonald, F. A.,	*Sacramento*	19
MacDonald, R. P.,	*Los Angeles*	10
Mace, L. S.,	*San Francisco*	23
Macfarlane, D. A.,	*Berkeley*	1
Mack, A. E.,	*Glendale*	10
Mack, C. W.,	*Livermore*	1
MacKay, C. H.,	*Los Angeles*	10
MacKay, E. M.,	*La Jolla*	22
Mackay, J. G.,	*Auburn*	17
Mackenzie, W. W.,	*Hollywood*	10
Mackey, J. G.,	*San Fernando*	10
MacKinnon, D. S.,	*W. Los Angeles*	10
Macklin, R. K.,	*Pasadena*	10
MacLafferty, N. C.,	*Soquel*	29
MacLean, H.,	*Los Angeles*	10
MacLean, H. G.,	*Oakland*	1
MacLean, J.,	*Los Angeles*	10
Maclennan, A. L.,	*Pasadena*	10
MacMillan, D. W.,	*Los Angeles*	10
MacMillan, H. A.,	*Long Beach*	10
Macomber, E. B.,	*Burlingame*	26
Macomber, H. W.,	*Burlingame*	26
Macpherson, D. G.,	*San Francisco*	23
Macpherson, F. L.,	*San Diego*	22
Macpherson, J. D.,	*San Diego*	22
Macpherson, W. E.,	*Los Angeles*	10
Madsen, L. J.,	*Santa Monica*	10
Magan, P. T.,	*Los Angeles*	10
Magan, W. P.,	*Covina*	10
Mahan, J. A.,	*Oxnard*	37
Maghy, C. A.,	*Los Angeles*	10
Magid, H. J.,	*Los Angeles*	10
Maginn, E. F.,	*Los Angeles*	10
Magoon, L. B.,	*San Jose*	28
Magrath, W. A. S.,	*Oakland*	1
Maguire, J. M.,	*San Diego*	22
Mahan, L. B.,	*San Diego*	22
Mahannah, L. D.,	*Long Beach*	10
Mahon, E. J.,	*San Francisco*	23
Mahoney, L. E.,	*Santa Monica*	10
Main, R. C.,	*Santa Barbara*	27
Mainwaring, G. F.,	*Oakland*	1
Maisler, S.,	*San Francisco*	23
Majer, R. G.,	*Los Angeles*	10
Majors, E. A.,	*Oakland*	1
Maker, R. W.,	*Norwalk*	10
Makinson, F. R.,	*Oakland*	1
Malcomson, O. K.,	*Hynes*	10
Malis, S.,	*Los Angeles*	10
Malkin, G. M.,	*Huntington Park*	10
Malmgren, G. E.,	*Los Angeles*	10
Malone, M. C.,	*San Francisco*	23
Malone, W. M.,	*San Francisco*	23
Maloney, H. P.,	*Oakland*	1
Maloney, W. M.,	*Los Angeles*	10
Mandel, G.,	*Los Angeles*	10
Maner, G. D.,	*Los Angeles*	10
Mangan, P. J.,	*San Francisco*	23
Manger, J.,	*San Bernardino*	21
Manjos, P.,	*San Francisco*	23
Manley, D. J.,	*Hayward*	1
Mann, A. I.,	*Los Angeles*	10
Mann, H. H.,	*Los Angeles*	10
Mann, V. L.,	*La Habra*	10
Mannerstedt, G. O.,	*Oakland*	1
Manning, J. G.,	*Los Angeles*	10
Manning, T. P.,	*Los Angeles*	10
Manning, W. R.,	*Fillmore*	37
Manny, M. A.,	*Pasadena*	10
Manor, A.,	*Monterey*	14
Mansfeldt, J. H.,	*San Francisco*	23
Manson, G.,	*Fresno*	4
Manson, R. M.,	*Hayward*	1
Mantle, V. M.,	*Los Angeles*	10
Manton, W. W.,	*Pasadena*	10
Manuel, M. M.,	*Pasadena*	10
Mapes, R. W.,	*Beverly Hills*	10
March, H. N.,	*Grass Valley*	17
Marchildon, J. W.,	*Los Angeles*	10
Marco, J.,	*Los Angeles*	10
Marcus, D. B.,	*Central Valley*	6
Marcus, H.,	*San Francisco*	23
Marcus, S. M.,	*Los Angeles*	10
Marians, A.,	*Los Angeles*	10
Mariette, E. L.,	*Glendale*	10
Mark, A. E.,	*Los Angeles*	10
Markel, H. H.,	*San Francisco*	23
Markolf, H. F.,	*Pasadena*	10
Marks, J. H.,	*Los Angeles*	10
Marks, M.,	*Long Beach*	10
Marks, R. F.,	*San Francisco*	23
Marks, S. H.,	*Pittsburg*	3
Markthaler, E. L.,	*Santa Barbara*	27
Marlo, J. A.,	*Los Angeles*	10
Marlow, A. A.,	*La Jolla*	22
Marnell, F. S.,	*Stockton*	24
Maroon, J. L.,	*Santa Ana*	16
Marquis, C. E.,	*Oakland*	1

NAME	CITY	COUNTY SOCIETY NO.
Marr, J. B.,	*Covina*	10
Marriott, J. L.,	*Alameda*	1
Marsden, C. S.,	*San Diego*	22
Marsden, S. A.,	*Santa Ana*	16
Marsh, C.,	*Sebastopol*	33
Marsh, O. G.,	*San Diego*	22
Marshall, B. M.,	*Eureka*	5
Marshall, H. K.,	*Glendale*	10
Marshall, J. M.,	*San Luis Obispo*	25
Marshall, O. C.,	*Watsonville*	29
Marston, C. B.,	*San Rafael*	11
Marston, H. E.,	*San Rafael*	11
Martin, A. T.,	*Los Angeles*	10
Martin, G. S.,	*Susanville*	9
Martin, H. H.,	*Riverside*	18
Martin, H. W.,	*Los Angeles*	10
Martin, J. N.,	*Colton*	21
*Martin, J. P.,	*Oakland*	1
Martin, L. A.,	*Berkeley*	1
Martin, L. E.,	*Los Angeles*	10
Martin, M. L.,	*Los Angeles*	10
Martin, P. T.,	*San Jose*	28
Martin, R. C.,	*San Francisco*	23
Martin, R. C.,	*San Bernardino*	21
Martin, W. C.,	*Tracy*	24
Martine, A.,	*La Jolla*	22
Martins, S. M.,	*Los Angeles*	10
Martyn, G.,	*Los Angeles*	10
Marx, R.,	*Los Angeles*	10
Marxer, W. L.,	*Beverly Hills*	10
Mason, B. B.,	*Laguna Beach*	16
Mason, B. S.,	*San Jose*	28
Mason, C. A.,	*Loma Linda*	21
Mason, C. V.,	*Livermore*	1
Mason, H. E.,	*Redwood City*	26
Mason, H. M.,	*Los Angeles*	10
Mason, M. I.,	*San Jose*	28
Mason, V. R.,	*Los Angeles*	10
Massey, B. D.,	*Pasadena*	10
Masters, E. J.,	*San Francisco*	23
Masterson, J. R.,	*Berkeley*	1
Mathé, C. P.,	*San Francisco*	23
Mather, R. W.,	*Los Angeles*	10
Mathes, M. E.,	*San Francisco*	23
Mathews, B. D.,	*San Francisco*	23
Mathews, S. S.,	*Los Angeles*	10
Mathewson, C.,	*Fresno*	4
Mathewson, C., Jr.,	*San Francisco*	23
Mathias, C. M.,	*Tulare*	36
Matlock, T. T.,	*Wasco*	7
Matousek, W. J.,	*Glendale*	10
Matson, J. R.,	*San Diego*	22
Matteo, R. L.,	*Oakland*	1
Mattison, C. W.,	*Los Angeles*	10
Mattison, J. A.,	*Sawtelle*	10
Mattison, S. J.,	*Pasadena*	10
Matzger, E.,	*San Francisco*	23
Mauer, E. F.,	*Los Angeles*	10
Maupin, J. L., Jr.,	*Fresno*	4
Mauser, C. L.,	*Oakland*	1
Mawdsley, H. L.,	*San Mateo*	26
Maximov, G. N.,	*San Francisco*	23
Maxson, E. S.,	*Alhambra*	10
Maxwell, A. H.,	*Sausalito*	11
Maxwell, D. M.,	*Santa Barbara*	27
Maxwell, H. C.,	*Santa Ana*	16
Maxwell, R. E.,	*Modesto*	34
May, H. C.,	*Los Angeles*	10
May, J. A.,	*San Diego*	22
May, L. B.,	*Bakersfield*	7
Mayer, H. J.,	*Los Angeles*	10
Mayers, M. M.,	*Los Angeles*	10
Mayfield, C.,	*Long Beach*	10
Mayman, E.,	*Modesto*	34
Maynard, M. T-R.,	*San Jose*	28
Mays, A. H.,	*Sausalito*	11
McAllister, H. R.,	*Taft*	7
McAllister, O. O. T.,	*Oakland*	1
McAnally, J. F.,	*Roseville*	17
McArthur, D. D.,	*Los Angeles*	10
*McArthur, P. R.,	*Los Angeles*	10
McAtee, J. S.,	*Los Angeles*	10
McAulay, M.,	*Monterey*	14
McAuley, J.,	*Santa Ana*	16
McBride, R. W.,	*Burlingame*	26
McBurney, B. A.,	*Pomona*	10
McBurney, R. D.,	*Los Angeles*	10
McCallister, C. H.,	*Los Angeles*	10
McCann, F. E.,	*Monrovia*	10
McCarthey, A. M.,	*Los Angeles*	10
McCarthy, F. J.,	*San Francisco*	23
McCarthy, H. L.,	*Los Angeles*	10
McCarthy, J. B.,	*Carmel*	14
McCarthy, J. J.,	*Bakersfield*	7
McCartney, O. D.,	*Glendale*	10
McCarty, R. B.,	*Riverside*	18
McCausland, A. M.,	*Los Angeles*	10
McCausland, J. D.,	*San Diego*	22
McCausland, W. S.,	*Chula Vista*	22
McChesney, G. J.,	*San Francisco*	23
McCleave, T. C.,	*Berkeley*	1
McCleave, T. C., Jr.,	*Oakland*	1
McClelland, E. S.,	*Los Angeles*	10
McClendon, S. J.,	*San Diego*	22
McClintock, G. L.,	*San Diego*	22
McClure, G.,	*Oakland*	1
McClure, J. C.,	*Lindsay*	36
McClurkin, A. A.,	*Los Angeles*	10

NAME	CITY	COUNTY SOCIETY NO.
McColl, J. M.,	*San Diego*	22
McColl, W. F.,	*San Diego*	22
McCombs, V. J.,	*Los Angeles*	10
McConnell, J. B.,	*Stirling City*	2
McConnell, O. G.,	*San Jose*	28
McCool, J. L.,	*San Francisco*	23
McCool, W. F.,	*Los Angeles*	10
McCorkle, H. J.,	*San Francisco*	23
McCoskey, G.,	*Stockton*	24
McCoy, C. A.,	*Los Angeles*	10
McCoy, E. T.,	*Los Angeles*	10
McCoy, H. H.,	*Long Beach*	10
McCracken, J. H.,	*San Pedro*	10
McCradie, R. D.,	*Oakland*	1
McCrea, F. R.,	*Long Beach*	10
McCullough, F. E.,	*No. Sacramento*	1
McCullough, J. M.,	*Crockett*	3
McCune, S. S.,	*Los Angeles*	10
McCuskey, C. F.,	*Glendale*	10
McDermott, J. C.,	*Los Angeles*	10
McDonald, A. C.,	*Huntington Park*	10
McDonald, F. X.,	*Los Angeles*	10
McDonald, G. H.,	*Ocean Beach*	22
McDonald, J.,	*San Francisco*	23
McDonnell, C. H.,	*Sacramento*	19
McDougall, M. W.,	*Long Beach*	10
McDowell, B. E.,	*Merced*	13
McDowell, C. A.,	*Covina*	10
McElhinney, P. P. B.,	*Long Beach*	10
McEvers, A. E.,	*Los Angeles*	10
McFarlane, A. H.,	*Mountain View*	28
McGarvey, H.,	*Atascadero*	25
McGee, R. P.,	*Los Angeles*	10
McGee, W. B.,	*San Diego*	22
McGehee, W. H.,	*Fresno*	4
McGill, P. R.,	*Hollywood*	10
McGinnis, J. J.,	*San Francisco*	23
McGovern, B. E.,	*San Fernando*	22
McGovney, R. B.,	*Santa Barbara*	27
McGowan, D. O.,	*Los Angeles*	10
McGranahan, J. H.,	*Long Beach*	10
McGrath, A. K.,	*Sonoma*	15
McGraw, L. S.,	*Portland, Ore*	25
McGreane, F. X.,	*Calistoga*	15
McGrew, W. R.,	*Oakland*	1
McGuinness, J. E.,	*San Francisco*	23
McGuinness, J. S.,	*San Francisco*	23
McGuire, F. A.,	*Stockton*	24
McGuire, J. B.,	*Mt. Shasta*	31
McGuire, J. J.,	*San Francisco*	23
McGuire, T. E.,	*Burbank*	10
McGurk, R. T.,	*Stockton*	24
McHugh, J. A.,	*Stockton*	24
McHugh, P. H.,	*Stockton*	24
McHugh, T. R.,	*Los Angeles*	10
McIntosh, A. M.,	*Berkeley*	1
McInturff, D. N.,	*Eureka*	5
McIvor, R. J.,	*Oakland*	1
McKay, J. J., Jr.,	*San Francisco*	23
McKee, C. B.,	*Sacramento*	19
McKee, E. N.,	*Eagle Rock*	10
McKee, K. S.,	*Bakersfield*	7
McKee, W. C.,	*Los Angeles*	10
McKeever, F. M.,	*Los Angeles*	10
McKellar, J. H.,	*Pasadena*	10
McKelvy, R. W.,	*Los Angeles*	10
McKenna, W. J.,	*Los Angeles*	10
McKenney, A. C., Jr.,	*San Francisco*	23
McKenney, J. A.,	*Oakland*	1
McKenney, P. W.,	*Alturas*	9
McKenzie, C. R.,	*Oakland*	1
McKenzie, R. B.,	*San Francisco*	23
McKibbin, J.,	*Los Angeles*	10
McKinnon, A. A.,	*Placerville*	19
McKinnon, D. D.,	*Los Angeles*	10
McKitrick, J. F.,	*Los Angeles*	10
McKnight, W. B.,	*Portola*	9
McLain, L. C.,	*Bakersfield*	7
McLaughlin, R. C.,	*Los Angeles*	10
McLaughlin, T. H.,	*Hollywood*	10
McLean, D.,	*Sacramento*	19
McLeish, A. H.,	*Yountville*	15
McLellan, G. H.,	*San Diego*	22
McLeod, F. L.,	*Hollywood*	10
McLeod, J. H.,	*Santa Rosa*	33
McManus, F. P.,	*Esparto*	38
McMaster, P. E.,	*Los Angeles*	10
McMillan, E. H.,	*Pasadena*	10
†McMurdo, P. F.,	*San Francisco*	23
McNamara, D.,	*Santa Barbara*	27
McNamara, D. H.,	*Santa Barbara*	27
McNaught, H.,	*San Francisco*	23
McNaught, J. B.,	*San Francisco*	23
McNaught, R. C.,	*San Francisco*	23
McNearney, J. J.,	*Merced*	14
McNeil, D.,	*Sacramento*	19
McNell, H. G.,	*Los Angeles*	10
McNell, W. T.,	*Stockton*	24
McNeile, L. G.,	*Los Angeles*	10
McNeile, O. M.,	*Los Angeles*	10
McNulty, A. H.,	*San Francisco*	23
McPharlin, J. H.,	*Salinas*	14
McPhee, V. C.,	*San Francisco*	23
McPheeters, E. R.,	*Modesto*	34
McPherson, H. A.,	*Los Angeles*	10
McPherson, M. D.,	*Santa Cruz*	29
McQuade, J.,	*San Francisco*	23
McRae, C. C.,	*San Francisco*	23

NAME	CITY	COUNTY SOCIETY NO.
McReynolds, M. C.,	*Angwin*	15
McReynolds, R. P.,	*Los Angeles*	10
McReynolds, R. T.,	*Santa Monica*	10
McWhirter, W. L.,	*Centerville*	1
Mead, C. I.,	*Bakersfield*	7
Meade, F. J.,	*Los Angeles*	10
Meads, A. M.,	*Oakland*	1
Meals, R. W.,	*Los Angeles*	10
Means, P. C.,	*Santa Barbara*	27
Meherin, J. M.,	*San Francisco*	23
Mehlin, G. B.,	*San Diego*	22
Mehrmann, H. B.,	*Oakland*	1
Meininger, W. M.,	*San Francisco*	23
Meland, O. N.,	*Los Angeles*	10
Melkonian, L.,	*Gilroy*	28
Mell, C. N.,	*Oakland*	1
Mellinger, H. V.,	*Los Angeles*	10
Mellinger, W. J.,	*Santa Barbara*	27
Mello, H.,	*Alameda*	2
Melnik, M.,	*Los Angeles*	10
Mendelsohn, L.,	*Saratoga*	28
*Meneray, P. A.,	*Santa Rosa*	33
Mensor, M. C.,	*San Francisco*	23
Mentzer, M. J.,	*San Francisco*	23
Mentzer, S. H.,	*San Francisco*	23
Merchant, A. K.,	*Stockton*	24
Meredith, H. H.,	*Oakland*	1
Merkle, H. J.,	*Los Angeles*	10
Mermod, C.,	*Oakland*	1
Mermod, L. E.,	*Lanai City, Lanai,* T. H.	3
Merrill, A. P.,	*San Francisco*	23
*Merrill, B. E.,	*Oakland*	1
Merrill, H. G.,	*San Diego*	22
Merrill, H. P.,	*Los Angeles*	10
Merrill, J. A.,	*Monterey*	14
Merrill, R. E.,	*Burbank*	10
Merrill, W. I.,	*Campbell*	28
Merrithew, E. W.,	*Martinez*	3
Merritt, R. E.,	*San Francisco*	23
Mesirow, M. E.,	*Santa Maria*	27
†Mettier, S. R.,	*San Francisco*	23
Metzner, A.,	*Los Angeles*	10
Meuser, A. H.,	*Corning*	35
Meyenberg, W. D.,	*Salinas*	14
Meyer, A. J.,	*Glendale*	10
Meyer, H. A.,	*San Francisco*	23
Meyerfeld, F.,	*Redwood City*	26
Meyers, E. L.,	*Chico*	2
Meyers, E. M.,	*Oakland*	1
Miano, B. D. A.,	*San Bernardino*	21
Michael, L.,	*San Leandro*	1
Michael, P. P.,	*Oakland*	1
Michels, L. M.,	*San Francisco*	23
Michelson, L.,	*San Francisco*	23
Michelson, P. D., Jr.,	*San Francisco*	23
Mikels, B. M.,	*Long Beach*	10
Mikels, F. M.,	*Palms*	10
Miles, R. H.,	*Alameda*	1
Miles, S. H.,	*Santa Monica*	10
Milholland, W. G.,	*Fresno*	4
Millar, G. E.,	*Sacramento*	19
Miller, A.,	*San Rafael*	11
Miller, A. H.,	*Los Angeles*	10
Miller, A. V.,	*Porterville*	36
Miller, A. W.,	*Riverside*	18
Miller, B. F.,	*Yuba-Sutter*	39
Miller, B. F.,	*Whittier*	10
Miller, C. D.,	*Glendale*	10
Miller, C. M., Jr.,	*Olive View*	10
Miller, D. G.,	*Los Angeles*	10
Miller, E. P.,	*Riverside*	18
Miller, F. F.,	*San Diego*	22
Miller, F. P.,	*Los Angeles*	10
Miller, G. B.,	*San Francisco*	23
Miller, H.,	*Los Angeles*	10
Miller, H. A.,	*Los Angeles*	10
Miller, H. E.,	*San Francisco*	23
Miller, I. S.,	*Colton*	21
Miller, J. E.,	*Los Angeles*	10
Miller, J. J., Jr.,	*San Francisco*	23
Miller, L. G.,	*Imola*	15
Miller, N.,	*Porterville*	36
Miller, N. D.,	*Los Angeles*	10
Miller, P. D.,	*Dinuba*	36
Miller, R. B.,	*Glendale*	10
Miller, R. F.,	*Los Angeles*	10
Miller, R. R.,	*Pasadena*	10
Miller, R. W.,	*Los Angeles*	10
Miller, S. J.,	*Long Beach*	10
Miller, T.,	*San Diego*	22
Miller, T. K.,	*Camarillo*	37
Miller, W. J.,	*Los Angeles*	10
Miller, W. McC.,	*Auburn*	17
Milligan, H.,	*Los Angeles*	10
Milliken, J. H.,	*Oakland*	1
Milliken, W. P.,	*Oakland*	1
Mills, L.,	*Los Angeles*	10
Mills, W.,	*Oakland*	1
Mills, W. W.,	*San Mateo*	26
Millspaugh, W. P.,	*Los Angeles*	10
Millzner, R. J.,	*San Francisco*	23
Milo, H. W.,	*Mountain View*	28
Milton, J. T.,	*San Diego*	22
Minna, J. B.,	*San Diego*	22
Misch, H. B.,	*Los Angeles*	10
Missall, A. S.,	*Santa Maria*	27
Missner, F. R.,	*Oakland*	1

NAME	CITY	COUNTY SOCIETY NO.
Mitchell, C. O.,	*Fresno*	4
Mitchell, C. S.,	*Fresno*	4
Mitchell, H. H.,	*Oakland*	1
Mitchell, T. T.,	*Brawley*	6
Mitchell, W. E.,	*Berkeley*	1
Mizel, M. L.,	*San Francisco*	23
Mizener, M.,	*Southgate*	10
Miyauchi, Y.,	*Santa Maria*	27
Mock, D. C.,	*Redlands*	21
Modern, F. S.,	*Los Angeles*	10
Moes, R. J.,	*Los Angeles*	10
Moffat, W. McK.,	*Santa Barbara*	27
Moffitt, E. J.,	*Los Angeles*	10
Moffitt, H. C.,	*San Francisco*	23
Mogan, R. F.,	*Los Angeles*	10
Mohs, O. K.,	*San Francisco*	23
Mohun, C. C., Jr.,	*San Francisco*	23
Mohun, M.,	*San Mateo*	26
Molgaard, J.,	*San Francisco*	26
Molitor, N.,	*San Diego*	22
Mollath, A. L.,	*Guadalupe*	27
Molony, C. J.,	*Los Angeles*	10
Molony, W. R.,	*Los Angeles*	10
Molony, W. R., Jr.,	*Los Angeles*	10
Monaco, S. R.,	*Los Angeles*	10
Monson, L. P.,	*San Francisco*	23
Montalvan, J.,	*Oakland*	1
Monteith, R. F.,	*Redwood City*	26
Montgomery, C. H.,	*Beverly Hills*	10
Montgomery, D. W.,	*San Francisco*	23
*Montgomery, J. L.,	*Mandovi, Wis.*	10
*Montgomery, M. F.,	*San Francisco*	23
Montgomery, M. L.,	*San Francisco*	23
Montgomery, W. O.,	*San Francisco*	23
Moodie, A. R.,	*Taft*	7
Moody, A. M.,	*San Francisco*	23
Moody, E. E.,	*Los Angeles*	10
Mooney, H. S.,	*Los Angeles*	10
Mooney, T. S.,	*San Diego*	22
Moor, F. B.,	*Los Angeles*	10
Moore, A. H.,	*Los Angeles*	10
Moore, A. W.,	*Los Angeles*	10
Moore, C. B.,	*San Francisco*	23
Moore, C. E.,	*San Jose*	28
Moore, C. L.,	Bakersfield	7
Moore, E. C.,	*Los Angeles*	10
Moore, F. H.,	*San Francisco*	23
Moore, G.,	*Oakland*	1
Moore, G. W.,	*Los Angeles*	10
Moore, H. A.,	*Berkeley*	1
Moore, J. B.,	*Fresno*	4
Moore, J. K.,	*Los Angeles*	10
Moore, J. M.,	*San Francisco*	23
Moore, J. W.,	*Quincy*	9
Moore, J. W.,	*Ventura*	37
Moore, L.,	*San Francisco*	23
Moore, L. S.,	*San Jose*	28
Moore, M. H.,	*Fresno*	4
Moore, N. L.,	*Santa Ana*	16
Moore, O. M.,	Bell	10
Moore, P. H.,	*Hollywood*	10
Moore, R.,	*Los Angeles*	10
Moore, R. W.,	*Los Angeles*	10
Moore, W. G.,	*San Francisco*	23
Moore, W. H.,	*Bakersfield*	7
Moose, R. M.,	*San Bernardino*	21
Mooy, J. E.,	*Covelo*	12
Mordoff, C. E.,	*Oakland*	1
More, D. H.,	*Long Beach*	10
Moretti, R.,	*Los Banos*	13
Morgan, J. D., Jr.,	*Fresno*	4
Morgan, J. W.,	*San Francisco*	23
Morgan, M. D.,	*San Francisco*	23
Morken, E. H.,	*Martinez*	3
Morley, F. J.,	*Upper Lake*	12
Morris, B. G.,	*Indio*	18
Morris, C. A.,	*Bakersfield*	7
Morris, E.,	*Auberry*	4
Morris, F. J.,	*Los Angeles*	10
Morris, G. H.,	*Santa Maria*	27
Morris, J. K., Jr.,	*Modesto*	34
Morris, K. G.,	*Petaluma*	33
Morris, L. M.,	*San Francisco*	23
Morris, M.,	*San Francisco*	23
Morris, R. H.,	*San Francisco*	23
Morris, R. L.,	*San Francisco*	23
Morrison, A. A.,	*Santa Paula*	37
Morrison, G. M.,	*San Mateo*	26
Morrison, L. F.,	*San Francisco*	23
Morrison, N. D.,	*San Mateo*	26
Morrison, N. D., Jr.,	*San Mateo*	26
Morrison, R. J.,	*Santa Monica*	10
Morrison, W. A.,	*Los Angeles*	10
Morrissey, E. J.,	*San Francisco*	23
Morrow, A.,	*Richmand*	3
Morrow, H.,	*San Francisco*	23
Morse, C. O.,	*Redwood City*	26
Morse, D. L.,	*Gilray*	28
Morse, H. A.,	*Oakland*	1
Mortensen, E. S.,	*Santa Monica*	10
Mortensen, J. P.,	*Los Angeles*	10
Mortensen, W. L.,	*Culver City*	10
Mortensen, W. S.,	*Santa Monica*	10
Morton, A. W.,	*San Francisco*	23
Morton, D. G.,	*San Francisco*	23
Morton, L. B.,	*Los Angeles*	10
Mosby, G.,	*Oakland*	1
Mosher W. F.,	*Ventura*	37

NAME	CITY	COUNTY SOCIETY NO.
Moss, A. J.,	*Los Angeles*	10
Motchan, L. A.,	*Los Angeles*	10
Mote, C. D.,	*San Francisco*	23
Motley, E. G.,	*Santa Ana*	16
Mott, E. L.,	*Fresno*	4
Mottram, L. D.,	*Modesto*	34
Moulton, D. H.,	*Chico*	2
Moulton, R. R.,	*San Mateo*	26
Mourer, L. A.,	*Los Angeles*	10
Movitt, S. I.,	*Los Angeles*	10
Movius, C. McK.,	*Los Angeles*	10
Movius, H. J.,	*Los Angeles*	10
Moyle, C. A.,	*Merced*	13
Muckleston, H. S.,	*Los Angeles*	10
Mudd, J. L.,	*Merced*	13
Mudd, S. G.,	*San Marino*	10
Mueller, R. R.,	*Los Angeles*	10
Mugford, I. K.,	*Sacramento*	19
Mugler, F. R.,	*San Luis Obispo*	25
Muhl, A. M.,	*San Francisco*	22
Muir, J. C.,	*San Jose*	28
Mulder, E. I.,	*Compton*	10
Mulfinger, C. L.,	*Los Angeles*	10
Mullaly, E. F.,	*Vallejo*	32
Mullen, E. W.,	*Agnew*	28
Mullen, J. L.,	*Sacramento*	19
Mullen, T. F.,	*San Francisco*	23
Mullenix, R. B.,	*San Diego*	22
Mulligan, H. R.,	*Hollywood*	10
Mulvehill, W.,	*Los Angeles*	10
Munch, P. F.,	*Santa Barbara*	27
Mundall, B. P.,	*Glendale*	10
Munter, E. J.,	*San Francisco*	23
Murakami, K.,	*Salinas*	14
Muramoto, J.,	*Sacramento*	19
Murphy, H. C.,	*Big Sur*	14
Murphy, J. B.,	*San Mateo*	26
Murphy, J. E.,	*Sacramento*	19
Murphy, J. M.,	*Oakland*	1
Murphy, K. M.,	*San Francisco*	23
Murphy, M. J.,	*Redding*	30
Murphy, W. H.,	*San Mateo*	26
Murray, D. H.,	*Napa*	15
Murray, S.,	*Los Angeles*	10
Murrieta, A. J.,	*Los Angeles*	10
Musante, A. S.,	*San Francisco*	23
Musselman, W. H.,	*South San Francisco*	26
Musser, L. P.,	*Oakland*	1
Myers, A. D.,	*Baldwin Park*	10
Myers, C.,	*Los Angeles*	10
Myers, G. E.,	*Los Angeles*	10
Myers, L.,	*San Diego*	22
Myers, O. R.,	*Eureka*	5
Myers, T. C.,	*Los Angeles*	10

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NAME	CITY	COUNTY SOCIETY NO.
Nador, G.,	*Los Angeles*	10
Naeckel, H. W.,	*Riverside*	18
Naffziger, H. C.,	*San Francisco*	23
Naftzger, J. B.,	*Los Angeles*	10
Nagel, G. W.,	*San Francisco*	23
Nagelman, C. B.,	*Santa Barbara*	27
Nakano, Y.,	*Guadalupe*	27
Nass, F. C.,	*San Francisco*	23
Nasser, G. E.,	*San Francisco*	23
Nathanson, M. H.,	*Los Angeles*	10
Natzler, A.,	*Los Angeles*	10
Naughton, J. P.,	*Los Angeles*	10
Nauheim, H. S.,	*Los Angeles*	10
Nazarin, G. S.,	*San Francisco*	23
Neal, J. R.,	*Los Angeles*	10
Need, O. U.,	*Madera*	4
Neff, F. E.,	*Compton*	10
Negley, J. C.,	*Los Angeles*	10
Neighbor, J. W.,	*Arrowhead Springs*	21
Neil, J. M.,	*Oakland*	1
Nelson, A. E.,	*Los Angeles*	10
Nelson, A. N.,	*Los Angeles*	10
Nelson, C. E.,	*National City*	22
Nelson, C. F.,	*Los Angeles*	10
Nelson, C. H.,	*Los Angeles*	10
Nelson, C. R.,	*Oakland*	1
Nelson, C. V.,	*Los Angeles*	10
Nelson, E. A.,	*Los Angeles*	10
Nelson, E. S.,	*Los Angeles*	10
Nelson, F. H.,	*Los Angeles*	10
Nelson, H. C.,	*Santa Ana*	16
Nelson, H. M.,	*Barstow*	21
Nelson, J. E.,	*Lodi*	24
Nelson, L. G.,	*Long Beach*	10
Nelson, R. C.,	*Beverly Hills*	10
Nelson, R. F.,	*Oakland*	1
Nelson, W. N.,	*Fillmore*	37
Nerad, A. H.,	*Wilmington*	10
Nesburn, H. R.,	*Hollywood*	10
Nesche, G. E.,	*Oakland*	1
Neslund, H. C.,	*Anaheim*	16
Nethercut, R. A.,	*San Francisco*	23
Netzley, R. E.,	*Pasadena*	10
Neubert, A. D.,	*Redlands*	21
Neufeld, H. D.,	*Concord*	3
Neumann, E. V.,	*Hollywood*	10
Neville, J. E.,	*Glendale*	10
Nevin, J. L.,	*San Bernardino*	21
Nevius, F. P.,	*Antioch*	3
Nevius, J. W.,	*Los Angeles*	10

NAME	CITY	COUNTY SOCIETY NO.
Newbecker, C. G.	*Hanford*	8
*Newcomb, A. T.	*Pasadena*	10
Newel, C. D.	*Fresno*	4
Newell, E.	*San Jose*	28
Newell, R. R.	*San Francisco*	23
Newkirk, H. D.	*Anaheim*	16
Newman, A.	*San Francisco*	23
Newman, B. A.	*Los Angeles*	10
Newman, L.	*San Francisco*	23
Newman, M. H.	*Los Angeles*	10
Newman, R. W.	*Iowa City, Iowa*	32
Newman, W. H.	*San Diego*	22
Newman, W. W.	*San Francisco*	23
Newson, H. E.	*San Francisco*	23
Newton, A. H.	*Yreka*	31
Newton, E. B.	*Oakland*	1
Newton, H. D.	*San Diego*	22
Newton, W. C.	*San Diego*	22
Nicholas, C. Z.	*Santa Barbara*	27
*Nichols, F. C.	*Santa Monica*	10
Nichols, J. N.	*Los Angeles*	10
Nichols, R. C.	*Ontario*	21
Nichols, R. E.	*Woodland*	38
Nichols, W. E.	*Pasadena*	10
Nicholson, J.	*Los Angeles*	10
Nicholson, J. McG.	*Bakersfield*	7
Nicholson, J. W.	*Porterville*	36
Nicholson, R. M.	*Los Angeles*	10
Nicola, T.	Alhambra	10
Nicoll, J. R. P.	*Los Angeles*	10
Nider, G. K.	*Fresno*	4
Niebel, H. L.	*Palo Alto*	28
Niebergall, H. A.	*Los Angeles*	10
Nielsen, H. W.	*Fowler*	4
Nielsen, J. C. E.	*Pacific Beach*	22
Nielsen, J. M.	*Los Angeles*	10
Nielsen, J. W.	*Oxnard*	37
Nielson, K. A.	*Oakland*	1
Nielson, L. R.	*Fresno*	4
Niemand, F. G.	*San Francisco*	23
Nies, A.	*Orange*	16
Nies, C. A.	*Los Angeles*	10
Nilsson, J. P.	*Long Beach*	10
Nippert, E. F.	*Los Angeles*	10
Nisbet, T. W.	*Pasadena*	10
Nittler, A. N.	*Santa Cruz*	29
Nixon, A. C.	*Hollywood*	10
Nixon, N. K.	*Los Angeles*	10
Noall, E. T.	*Santa Rosa*	33
Noble, B. E.	*Los Angeles*	10
Noble, C. A., Jr.	*San Francisco*	23
Noble, T. E.	*Long Beach*	10
Noetling, P. R.	*Angels Camp*	24
Nolan, O. F.	*San Francisco*	23
Nolan, T. J.	*Pacific Grove*	23
Noland, C. A.	*Long Beach*	10
Norman, G. F.	*San Francisco*	23
Norman, J. G.	*San Pedro*	10
Norris, C. E.	*Eureka*	5
Norris, W. J.	*Los Angeles*	10
Northrop, R. S.	*Napa*	15
Northway, W. H.	*Stanford Univ.*	28
Norton, F. L.	*Los Angeles*	10
Norwood, G. E.	*Covina*	10
Novy, F. G.	*Oakland*	1
Noyes, F. Le G.	*Los Angeles*	10
Null, J. W.	*San Francisco*	23
Nuttall, J. P.	*Santa Monica*	10
Nutting, F. J.	*Santa Monica*	10
Nutting, R. J.	*Oakland*	1
Nuyens, L. C.	*San Francisco*	23
Nuzum, F. R.	*Santa Barbara*	27

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NAME	CITY	COUNTY SOCIETY NO.
Oakleaf, D. C.	*Healdsburg*	33
Obando, A. T.	*Los Angeles*	10
O'Brien, G.	*Sacramento*	19
O'Brien, H. J.	*Los Angeles*	10
O'Brien, J. J.	*Los Angeles*	10
O'Brien, J. W.	*Sacramento*	19
O'Connell, T. S.	*San Diego*	22
O'Connor, C. A.	*Santa Rosa*	33
O'Connor, G. B.	*San Francisco*	23
O'Connor, J. H.	*San Francisco*	23
O'Connor, R. E.	*Los Angeles*	10
O'Connor, R. P.	*Oakland*	1
O'Connor, S. M.	*San Francisco*	23
O'Connor, T. H.	*San Francisco*	23
O'Donnell, F. J.	*Stockton*	24
O'Donnell, J. M.	*Hollister*	20
Oechsli, W. R.	*Olive View*	10
Oftedal, S.	*Glendale*	10
Ogden, R. A.	*Bakersfield*	7
O'Grady, W. E.	*San Francisco*	23
Ohannesian, F.	*Sacramento*	19
Ohanneson, J.	*Alameda*	1
O'Hara, F. P.	*San Diego*	22
O'Hara, G. P.	*San Francisco*	23
O'Hara, J. J.	*San Diego*	22
Ohnemuller, C. E.	*Los Angeles*	10
Okami, S.	*Terminal Island*	10
Okonogi, B.	*Fresno*	4
Olch, I. Y.	*Los Angeles*	10
Oldenbourg, L. A.	*Berkeley*	1
Olberg, F. H.	*Redding*	30
Olds, W. H.	*Los Angeles*	10
Olhoffer, C. J.	*Pasadena*	10
Oliva, M. R.	*San Francisco*	26
Oliver, A.	*Imola*	15
Oliver, H. R.	*San Francisco*	23
Oliver, J. V.	*Palm Springs*	18
Oliver, W. A.	*San Francisco*	23
Olmsted, R. C.	*Pasadena*	10
Olney, M. B.	*San Francisco*	23
Olsen, A. Y.	*Los Angeles*	10
Olsen, C. W.	*Los Angeles*	10
Olsen, D. M. R.	*Berkeley*	1
Olsen, E. R.	*San Francisco*	23
Olsen, G. W.	*Fresno*	4
Olsen, J.	*Oakland*	1
Olsen, S.	*San Francisco*	23
Olsen, X.	*San Bernardino*	21
Olson, G. M.	*Los Angeles*	10
Olson, G. W.	*Fullerton*	16
Omelvcna, J. G.	*San Diego*	22
*O'Neil, A. A.	*San Francisco*	23
O'Neil, F. H.	*Eureka*	5
O'Ncill, B. J., Jr.	*San Diego*	22
O'Neill, J. N.	*Los Angeles*	10
O'Neill, T. J.	*Los Angeles*	10
Onesti, S. J.	*San Francisco*	23
Oppenheimer, L. I.	*Oakland*	1
Orcutt, A. H.	*Oakland*	1
Orella, F. R.	*San Francisco*	23
Ormsby, E. A.	*Centerville*	1
*Orr, J.	*Oakland*	1
Osborn, H. B.	*Fillmore*	37
Osborne, C. J.	*San Diego*	22
Osborne, R. H.	*Los Angeles*	10
Osburn, J. N. N.	*Los Angeles*	10
Osipow, S.	*San Francisco*	23
Ostroff, R. A.	*San Francisco*	23
Ostwald, E.	*San Francisco*	23
Otis, E. F.	*Brea*	16
Otis, N. M.	*Santa Monica*	10
Ottinger, M. R.	*San Francisco*	23
Otto, F. W.	*Los Angeles*	10
Ouer, R. A.	*San Diego*	22
Oviedo, G. F.	*San Francisco*	23
Oviedo, L. J.	*San Francisco*	23
Owen, C. C.	*San Bernardino*	21
Owen, C. S.	*National City*	22
Owen, E. D.	*San Francisco*	23
Owen, G. R.	*Los Angeles*	10
Owens, R. L.	*Lodi*	24
Owens, W. R.	*Glendale*	10
Oyler, J. D.	*Los Angeles*	10

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NAME	CITY	COUNTY SOCIETY NO.
Paap, G. F.	*Long Beach*	10
Pace, P. T.	*San Jose*	28
Packard, L. A.	*Bakersfield*	7
Padgett, V. W.	*Alleghany*	17
Paez, J.	*San Diego*	22
Page, B. H.	*San Mateo*	26
Page, C. W.	*Berkeley*	1
Page, E. W.	*Oakland*	1
Page, W. E.	*Oakland*	1
Pahl, B. W.	*Los Angeles*	10
Pahl, P. C. H.	*Los Angeles*	10
Paige, G. A.	*Anaheim*	16
Paine, N. C.	*Glendale*	10
Palamountain, W. B.	*Oakland*	1
Pallais, A.	*Los Angeles*	10
Pallesen, V. W.	*Walnut Grove*	19
Pallette, E. C.	*Los Angeles*	10
Pallette, E. M.	*Los Angeles*	10
Palmateer, R. H.	*Oceanside*	22
Palmer, B. M.	*Oakland*	1
Palmer, E. O.	*Hollywood*	10
Palmer, R. S.	*Pomona*	10
Palmer, W. B.	*Long Beach*	10
Palomeque, E. J.	*Los Angeles*	10
Paoli, T. H.	*San Francisco*	23
Paretzky, M.	*Los Angeles*	10
Park, D. B.	*Vallejo*	32
Parker, A. S.	*Merced*	13
Parker, C. H.	*Pasadena*	10
Parker, D. M.	*Oakland*	1
Parker, G.	*Salinas*	14
Parker, H. R.	*Oakland*	1
Parker, J. A.	*Merced*	13
Parker, J. A.	*Los Angeles*	10
Parker, J. L.	*Brawley*	6
Parker, J. T.	*Oakland*	1
Parker, L. O.	*San Francisco*	23
Parker, T. A.	*La Jolla*	22
Parker, W. B.	*Los Angeles*	10
Parkin, V.	*Los Angeles*	10
Parkinson, R. H.	*San Francisco*	23
Parkinson, S. N.	*Oakland*	1
Parkinson, S. R.	*Marysville*	39
Parkinson, W. B.	*Porterville*	36
Parks, B. K.	*Long Beach*	10
Parks, F. R.	*Los Angeles*	10
Parks, K. G.	*Long Beach*	16
Parks, R. V.	*Los Angeles*	10
Parowski, S. A.	*San Diego*	22
Parrish, C. R.	*Los Angeles*	10
Parrlsh, G.	*Los Angeles*	10
Parrott, J. C.	*San Francisco*	23
Parsons, H. H.	*Barksdale Field, La.*	21
Parsons, S. R.	*Santa Barbara*	27
Partch, W. T.	*Oakland*	1
Pasette, S. E.	*Los Angeles*	10
Pasley, H. W.	*Reedley*	4
Pate, W. H.	*Alturas*	9
Patek, S. D.	*San Francisco*	23
Patrick, M. A.	*Los Angeles*	10
Patterson, E. A.	*Berkeley*	1
Patterson, G. H.	*Los Angeles*	10
Patterson, G. L.	*Santa Rosa*	33
Pattcrson, J. A.	*San Bernardino*	21
Patterson, J. K.	*Santa Barbara*	27
Pattison, A. C.	*Pasadena*	10
Patton, E. F.	*Los Angeles*	10
Patton, H. S.	*Oakland*	1
Patton, W. G.	*Redlands*	24
Paul, C. J.	*Orange*	6
Paul, S. B.	*San Francisco*	23
Paull, R. A.	*La Jolla*	22
Paulson, J. E.	*San Francisco*	23
‡Paup, M. K.	*Kingman, Ariz.*	21
Paxman, D. G.	*Oakland*	1
Payne, R. C.	*Los Angeles*	10
Payne, S.	*Santa Barbara*	27
Pchelkin, N. A.	*San Francisco*	23
Pearce, C. M.	*Oakland*	1
Pearce, W. M.	*Wilmington*	10
Pearl, F. L.	*San Francisco*	23
Pearson, B. S.	*Los Angeles*	10
Pearson, C. E.	*Turlock*	34
Pearson, E. A.	*Los Angeles*	10
Pearson, R. G.	*Sacramento*	19
Peckham, G. M.	*Oakland*	1
Peddicord, H.	*Redwood City*	26
Pederson, C. B.	*Tahoe City*	17
Pedlow, L. L.	*Los Angeles*	10
Peeke, E. S.	*Weimar*	17
Peers, R. A.	*Colfax*	17
Peers, R. S.	*Oakland*	1
Peery, L. T.	*Berkeley*	1
Peirsol, E. C.	*Claremont*	10
Peirsol, M.	*Fresno*	4
Pelkan, K. F.	*San Jose*	28
Peluso, J. D.	*Los Angeles*	10
Pendergrass, C. I.	*Clovis*	4
Pendergrass, J. E.	*Clovis*	4
Pendleton, W. C.	*Los Angeles*	10
Pendleton, W. R.	*Long Beach*	10
Penn, H. S.	*Los Angeles*	10
Penn, L. L.	*San Francisco*	23
Pennington, A. S.	*San Francisco*	23
Penzotti, R. B.	*Oakland*	1
Peoples, S. Z.	*Petaluma*	33
Peppers, C. H.	*Los Angeles*	10
Percy, J. F.	*Los Angeles*	10
Perkins, H. B.	*Vallejo*	32
Perkins, W. A.	*Oakland*	1
Perry, C. G.	*Sausalito*	11
Perry, I. H.	*San Francisco*	23
Perry, J. R.	*West Hollywood*	10
Perry, O. H.	*Westwood*	39
Perzik, S. L.	*Los Angeles*	10
Petch, P. H.	*Oakland*	1
Peters, C.	*San Francisco*	23
Peters, C. E.	*Oakland*	1
Peters, H. E.	*Pittsburg*	3
Peters, L.	*Alameda*	1
Petersen, H. C.	*Stockton*	24
Petersen, H. E.	*San Fernando*	10
Peterson, A. A.	*Los Angeles*	10
Peterson, E. A.	*Vallejo*	32
Peterson, F. W.	*El Centro*	6
Peterson, J. B.	*Los Angeles*	10
Peterson, L. J.	*Lodi*	24
Peterson, M. H. A.	*Sierra Madre*	10
Petr, F.	*Turlock*	34
Petritz, L. J.	*Los Angeles*	10
Petter, R. S.	*Los Angeles*	10
Pettct, C. H.	*Los Angeles*	10
Pettis, J. H.	*Fresno*	4
Pettit, A. V.	*San Francisco*	23
Pettler, S. H.	*Los Angeles*	10
*Petty, C. O.	*Fullerton*	16
Pfeiffer, H. W.	*La Mesa*	22
Pflueger, O. H.	*San Francisco*	23
Phelan, C. A.	*San Francisco*	23
Phelps, L. B.	*Whittier*	10
Phetteplace, D. O.	*Fullerton*	16
Phillips, A. D.	*Sacramento*	19
Phillips, A. L.	*Santa Cruz*	29
Phillips, C. E.	*Los Angeles*	10
Phillips, L.	*Hollywood*	10
Phillips, L. F. E.	*Palo Alto*	28
Philp, W. S.	*Los Angeles*	10
Pickard, R. J.	*San Diego*	22
Pickworth, M. E.	*San Jose*	28
Pidcock, J. W.	*Hollywood*	10
Pier, H. McK.	*Oakland*	1
Pierce, G. W.	*San Francisco*	23
Pierce, H. F.	*Santa Barbara*	27
*Pierce, S. N.	*Los Angeles*	10
Pierson, P. H.	*San Francisco*	23
Pillsbury, S. G.	*Long Beach*	10
Pimentel, G. B.	*Los Banos*	13
Pindell, M. L.	*Los Angeles*	10
*Pindler, L. A.	*Los Angeles*	10
Piness, G.	*Los Angeles*	10
Pinkerton, B. G.	*Los Angeles*	10
Pinkham, C. B.	*San Francisco*	23
Pinkley, V. M.	*San Bernardino*	21

NAME	CITY	COUNTY SOCIETY NO.
Pinney, I.	*Stockton*	24
Piper, H. E.	*Santa Cruz*	29
Pischel, D. K.	*San Francisco*	23
Pischel, K.	*San Francisco*	23
Piscitelli, A. M.	*San Francisco*	23
Pitkin, H. C.	*San Francisco*	23
Pitts, E. H.	*Sacramento*	19
Pius, C.	*Yreka*	31
Plane, J. F.	*Long Beach*	10
Plank, T. H.	*San Francisco*	23
Plath, H. W.	*Oakland*	1
Platt, J. E.	*Pasadena*	10
Player, L. P.	*San Francisco*	23
Pleth, V.	*Santa Rosa*	33
Plimpton, E. B.	*Los Angeles*	10
Plumb, C. E.	*Chico*	2
Plymire, D. B.	*San Francisco*	23
Poage, C. A.	*Colusa*	38
Podstata, V. H.	*San Francisco*	1
Poheim, J. F.	*San Francisco*	23
Pohlman, D. A.	*San Diego*	22
Polesky, F. A.	*Iowa City, Iowa*	10
Poley, C. W.	*Los Angeles*	10
Poliak, P. P.	*San Francisco*	23
Polland, W. S.	*San Rafael*	11
Pollia, J. A.	*Los Angeles*	10
Pollock, W. E.	*Sacramento*	19
Polse, M. L.	*San Francisco*	23
Pomeroy, F. K.	*Fresno*	4
Pomeroy, G. T.	*Napa*	15
Pomeroy, J. L.	*Los Angeles*	10
Pond, S. B.	*Patton*	21
Poole, F. E.	*Glendale*	10
Poole, L. E.	*Santa Ana*	16
Pope, W. H.	*Sacramento*	19
Popkin, R. J.	*Los Angeles*	10
Port, W. W.	*San Francisco*	23
Porter, C. D.	*San Francisco*	23
Porter, E. E.	*San Jose*	28
Porter, J. A.	*Modesto*	34
Porter, J. I.	*Benicia*	32
Porter, M. E.	*Talmage*	12
Porter, R. L.	*San Francisco*	23
Posner, C.	*Pasadena*	10
Post, J. O.	*Los Angeles*	10
Poston, H. P.	*Pasadena*	10
Poth, E. J.	*San Francisco*	23
Pottenger, F. M.	*Monrovia*	10
Pottenger, F. M., Jr.	*Monrovia*	10
Pottenger, J. E.	*Monrovia*	10
Pottenger, R. T.	*Pasadena*	10
Potter, A.	*San Francisco*	23
*Potter, C. D.	*San Francisco*	23
Potter, G.	*Oakland*	1
Potter, H. G.	*Winters*	38
Potter, M. J. M.	*San Diego*	22
Potter, W. H.	*San Diego*	22
Pouppirt, P. S.	*San Francisco*	23
Powell, A.	*Lafayette*	1
Powell, B. J.	*Stockton*	24
Powell, B. J., Jr.	*Stockton*	24
Powell, D. R.	*Stockton*	24
Powell, F. G.	*Visalia*	36
Powell, R. C.	*Richmond*	3
Powell, T. O.	*Los Angeles*	10
Powell, W. A.	*Martinez*	3
Powers, A. R.	*Tracy*	24
Powers, E. S.	*Los Angeles*	10
Powers, H. J.	*Beverly Hills*	10
Powers, R. A.	*Palo Alto*	28
Poy, W. J.	*San Francisco*	23
Pratt, B. H.	*Lemoore*	8
Pratt, D. R.	*San Francisco*	23
Pratt, E. D.	*Burbank*	10
Pratt, M. D.	*Fall River Mills*	30
Pratt, O. B.	*Los Angeles*	10
Pratt, T. R., Jr.	*Pismo Beach*	25
Premo, M. A.	*San Jose*	28
Prescott, M. U.	*San Francisco*	23
Present, A. J.	*La Jolla*	22
Presnell, J. F.	*Los Angeles*	10
Pressley, J. F.	*San Francisco*	23
Pressman, J. J.	*Los Angeles*	10
Preston, A. W.	*Visalia*	36
Preston, H. E.	*Los Angeles*	10
Preuss, C. A.	*Santa Barbara*	27
Price, J. B.	*Santa Ana*	16
Price, L. G.	*Fresno*	4
Prien, R. H.	*Gilroy*	28
Priestley, S. F.	*Stockton*	24
Prigge, E. K.	*Los Angeles*	10
Primasing, R.	*Courtland*	19
Prince, C. C.	*Glendale*	10
Prince, L. D.	*San Francisco*	23
Prince, P. W.	*Long Beach*	10
Prince, R. W.	*San Bernardino*	21
Prindle, K. H.	*San Mateo*	26
Prinzmetal, M.	*Los Angeles*	10
Prisinzano, G.	*Sacramento*	19
Pritchard, F. H.	*Colton*	21
Pritchard, J. L.	*San Jose*	28
Pritchard, W. F.	*San Bernardino*	21
Probert, W. H.	*Berkeley*	1
Proescher, F.	*San Jose*	28
Profant, H. J.	*Santa Barbara*	27
Pruett, H. J.	*San Francisco*	23
Pryor, H. B.	*Palo Alto*	28
Pulford, D. S.	*Sacramento*	19
Purdy, A. P.	*San Francisco*	23
Purlenky, G. P.	*Arcata*	5
Pursell, F. J.	*Los Angeles*	10
Purviance, C. C.	*Fairfield*	32
Putnam, H. A.	*Monrovia*	10
*Putnam, V.	*San Francisco*	23
— Q —		
Quaintance, P. A.	*Los Angeles*	10
Quarry, P. T.	*Santa Rosa*	33
Quigley, J. S.	*Oakland*	1
Quimby, S. A.	*Madera*	4
Quinan, C.	*Nevada City*	17
Quinlan, C. M.	*Santa Rosa*	33
Quinlan, E. F.	*San Francisco*	23
Quinlan, J. F.	*San Francisco*	23
Quinn, T. D'A.	*San Francisco*	23
Quinn, V. J.	*Los Angeles*	10
Quinn, W. F.	*Los Angeles*	10
Quinn, W. J.	*Eureka*	5
Quirmbach, R. P.	*Spadra*	10
— R —		
Rabinowitz, R.	*San Francisco*	23
Rabwin, M. H.	*Los Angeles*	10
Racer, F. H.	*Lomita*	10
Rachmel, W.	*Los Angeles*	10
Radcliff, R. R.	*Modesto*	34
Radford, E. B.	*Walnut Creek*	3
Ragan, S. T.	*Los Angeles*	10
Rahn, P. C.	*San Leandro*	1
Railsback, O. C.	*Woodland*	38
Raitt, G. E.	*Santa Ana*	16
Rajotte, E. C. F.	*San Francisco*	23
Rakitin, S. S.	*San Francisco*	23
Rambo, W. H.	*Los Angeles*	10
Ramsay, R. E.	*Pasadena*	10
Rand, C. W.	*Los Angeles*	10
Randall, D. T.	*West Los Angeles*	10
Randall, S. B.	*Santa Cruz*	29
Randel, H. A.	*Fresno*	4
Raney, R. B.	*San Marino*	10
Ranker, E. R.	*Oakland*	1
Rankin, A. B.	*San Leandro*	1
Rankin, E. P.	*Berkeley*	1
Ransom, D. H.	*Madera*	4
Ransom, J. K.	*Modesto*	34
Ransom, J. R.	*San Luis Obispo*	25
Rapaport, H.	*Los Angeles*	10
Rapaport, W.	*Imola*	15
Raphael, J. C.	*Oakland*	1
Rasor, C.	*Oakland*	1
Rathbone, R. H.	*Los Angeles*	10
Ratliff, H. L.	*Riverside*	18
Ratner, R.	*San Francisco*	23
Ratty, F. J.	*San Diego*	22
Raulston, B. O.	*Los Angeles*	10
Ravenscroft, J. W.	*San Diego*	22
Rawlins, A. G.	*San Francisco*	23
Ray, E. B.	*Bellflower*	10
Ray, F. S.	*Los Angeles*	10
Ray, H. H.	*San Mateo*	26
Ray, L.	*Santa Rosa*	33
Raymond, A.	*San Francisco*	23
Rea, B. J.	*Sacramento*	19
Rea, J. G.	*Pomona*	10
Rea, R. R.	*Los Angeles*	10
Rea, S. L.	*Ukiah*	12
Read, F. T.	*Glendale*	10
Read, J. M.	*San Francisco*	23
Ready, F. L.	*Los Angeles*	10
Ream, M. P.	*San Leandro*	1
Reamer, E. F.	*Modesto*	34
Reardon, F. B.	*Sacramento*	19
Reasner, W. F.	*Santa Monica*	10
Rebec, W. G.	*Belmont*	26
ReBell, F. R. G.	*Holtville*	6
Reckers, W. A.	*Placerville*	19
Rector, J. M.	*San Francisco*	23
Redelings, L. H.	*San Diego*	22
Redewill, F. H.	*San Francisco*	23
Redfield, R. L.	*Berkeley*	1
Redmond, M. H.	*Huntington Park*	10
Reed, A. C.	*San Francisco*	23
Reed, C. C.	*Compton*	10
Reed, E. N.	*Santa Monica*	10
Reed, J. R.	*Pasadena*	10
Reed, W. W.	*Nevada City*	17
Reeder, C. W.	*Long Beach*	10
Reeng, J. D.	*San Francisco*	23
Rees, C. E.	*San Diego*	22
Rees, C. W.	*San Diego*	22
Rees, D. M.	*Monterey Park*	10
Rees, H. C.	*Los Angeles*	10
Rees, R. B.	*Bakersfield*	7
Reeves, D. L.	*Los Angeles*	10
Reeves, E. W.	*Salinas*	14
Reeves, J. E.	*San Diego*	22
Reeves, J. M.	*Oakland*	1
Reeves, J. W.	*Los Angeles*	10
Reeves, N. I.	*Loma Linda*	21
Reeves, W. R.	*Salinas*	14
Regan, L. J.	*Los Angeles*	10
Reich, A., Jr.	*San Francisco*	28
Reich, W. W.	*Berkeley*	1
Reiche, C.	*Los Angeles*	10
Reichert, F. L.	*San Francisco*	23
Reichle, P. A.	*Los Angeles*	10
Reid, R. B.	*Perris*	18
Reid, R. S.	*Oceanside*	22
Reilly, P. H.	*Vallejo*	32
Reilly, W.	*San Francisco*	23
Reilly, W. A.	*San Francisco*	23
Reina, S.	*Los Angeles*	10
Reinard, E.	*Los Angeles*	10
Reinertsen, B. R.	*Los Angeles*	10
Reinle, G. G.	*Oakland*	1
Reis, A. G. DeS.	*Oakland*	1
Reis, J. B.	*San Leandro*	1
Reische, A. E.	*Oakland*	1
Reiss, O.	*Los Angeles*	10
Reiss, T. H.	*Alameda*	1
Reitzel, R. J.	*San Mateo*	26
Remaly, C. E.	*Los Angeles*	10
Remington, L. D.	*Monrovia*	10
Remmel, A. J.	*San Francisco*	23
Remmen, E. T.	*Glendale*	10
Renner, J. H.	*Santa Barbara*	27
Renshaw, J. F.	*Cleveland, Ohio*	10
Ress, I. LeR.	*Los Angeles*	10
Rethwilm, L. A.	*San Francisco*	23
Reud, W. R.	*Oakland*	1
Rey, H. F.	*Oxnard*	37
Reyes, J. M. de l.	*Los Angeles*	10
Reynolds, C. E.	*Glendale*	10
Reynolds, F. C.	*Chico*	2
Reynolds, F. G.	*Los Angeles*	10
Reynolds, H. C.	*Arlington*	18
Reynolds, J.	*Los Angeles*	10
Reynolds, J. M.	*Long Beach*	10
Reynolds, L. G.	*Los Angeles*	10
Reynolds, L. R.	*San Francisco*	23
Reynolds, P. A.	*Los Angeles*	10
Reynolds, R. A.	*San Francisco*	23
Reynolds, T. E.	*Oakland*	1
Reynolds, W. J.	*San Anselmo*	11
Reznick, S.	*Los Angeles*	10
Rhind, R.	*Hermosa Beach*	10
Rhodes, G. K.	*San Francisco*	23
Rhone, T. B.	*Orange*	16
Rhymes, L. H.	*Canoga Park*	10
Riach, M. T.	*San Diego*	22
Rice, A. H.	*Berkeley*	1
Rice, C. H.	*Oakland*	1
Rice, F. M.	*San Francisco*	23
Richards, C. M.	*San Jose*	28
Richards, D. N.	*Oakland*	1
Richards, E. E.	*Burlingame*	26
Richards, J. C.	*Inglewood*	10
Richards, S. B.	*San Bernardino*	21
Richardson, G. C.	*Sonora*	24
Richardson, W. A.	*Loma Linda*	21
Richtel, P.	*Fresno*	4
Richter, C.	*Balboa Beach*	16
Richter, I. M.	*Santa Barbara*	27
Rickabaugh, H. B.	*Alhambra*	10
Rickard, J. F.	*San Francisco*	23
Riddell, O. J.	*Alhambra*	10
Riggin, L. L.	*Pasadena*	10
Riggle, O.	*Lodi*	24
Righetti, E.	*San Francisco*	23
Righetti, H.	*San Francisco*	23
Rinehart, J. F.	*San Francisco*	23
Rinkenberger, F. W.	*Los Angeles*	10
Riskind, L. A.	*Los Angeles*	10
Risley, E. H.	*Loma Linda*	21
Risser, J. C.	*Pasadena*	10
Ritchie, I. S.	*Riverside*	18
Rivera, G. A.	*Los Angeles*	10
Rivin, H. A.	*Delano*	7
*Rixford, E.	*San Francisco*	23
Rixford, E. L., Jr.	*San Francisco*	23
Rixford, H. C.	*Stockton*	24
Roath, C. A., Jr.	*Los Angeles*	10
Robarts, H. P.	*San Francisco*	23
Robbins, A. C.	*Garden Grove*	16
Robbins, A. R.	*Los Angeles*	10
Robbins, B.	*Hanford*	8
Robbins, D. R.	*Los Angeles*	10
Roberg, D. N.	*San Jose*	28
Roberts, A. M.	*Los Angeles*	10
Roberts, E. K.	*Los Angeles*	10
Roberts, G. J.	*Pomona*	10
Roberts, G. W.	*Oakland*	1
Roberts, J. G.	*Pomona*	10
Roberts, W. H.	*Pasadena*	10
Robertson, D. L.	*Modesto*	34
Robertson, G.	*Berkeley*	1
Robertson, H. R.	*Los Angeles*	10
Robertson, J. W., Jr.	*Livermore*	1
Robertson, R. R.	*San Rafael*	11
Robinson, H. H.	*Oakland*	1
Robinson, J.	*Anaheim*	16
Robinson, J. H.	*Los Angeles*	10
Robinson, J. M.	*San Francisco*	23
Robinson, J. W.	*Los Angeles*	10
Robinson, L. L.	*San Rafael*	11
Robinson, S. P.	*Santa Barbara*	27
Robinson, S. S.	*Los Angeles*	10
Robison, L. H.	*Los Angeles*	10
Roblee, W. W.	*Riverside*	18
Robson, G. B.	*San Francisco*	23
Rochex, F. J.	*San Francisco*	23
Rodenbaugh, F. H.	*San Francisco*	23

NAME	CITY	COUNTY SOCIETY NO.
Rodin, F. H.,	*San Francisco*	23
Roe, H. E.,	*Berkeley*	1
Roehm, E. A.,	*Los Angeles*	10
Roen, P. B.,	*Hollywood*	10
Roger, J. H. D.,	*San Francisco*	23
Rogers, E. L.,	*Loma Linda*	21
Rogers, H.,	*Oakland*	1
Rogers, H. S.,	*Petaluma*	33
Rogers, J. A.,	*San Francisco*	23
Rogers, J. B.,	*Napa*	15
Rogers, J. B.,	*Los Angeles*	10
Rogers, J. D.,	*Los Angeles*	10
Rogers, L. B.,	*Los Angeles*	10
Rogers, L. E.,	*Los Angeles*	10
Rogers, S.,	*Tulare*	36
Rogers, T. J.,	*Los Angeles*	10
Rogers, T. L.,	*Long Beach*	10
Rogers, W. C.,	*Pasadena*	10
Rogers, W. G.,	*Los Angeles*	10
Rogers, W. L.,	*San Francisco*	23
Rogozen, A.,	*San Jose*	28
Rohlfes, B. J.,	*San Francisco*	23
Rohrbacher, G. H.,	*Stockton*	24
Rolland, W. M.,	*Los Angeles*	10
Roller, C. S.,	*Woodland*	38
Rolph, W. D.,	*National City*	22
Rombeau, L. P.,	*Los Angeles*	10
Roncovieri, L.,	*San Francisco*	23
Rood, R. S.,	*Imola*	29
Rood, V. V.,	*Grass Valley*	17
Roome, A. E.,	*Los Angeles*	10
Roome, C. T.,	*Santa Barbara*	27
Rooney, C. E.,	*Santa Monica*	10
Rooney, H. M.,	*Los Angeles*	10
Roos, A. R.,	*Loma Linda*	21
Roos, D. D.,	*Corona*	18
Roos, V. O.,	*Redlands*	21
Root, P. N.,	*Bakersfield*	7
Root, R. N.,	*Huntington Park*	21
Root, R. R.,	*Corona*	18
Rosanoff, A. J.,	*Sacramento*	10
Rosasco, J. L.,	*Stockton*	24
Rosasco, O. L.,	*Saratoga*	28
Rosburg, A. H.,	*San Francisco*	23
Roscoe, A. M.,	*Newman*	34
Rose, C. M.,	*Los Angeles*	10
Rose, H. de W.,	*Sonora*	24
Rose, J. T.,	*Healdsburg*	33
Rose, L. M.,	*Santa Clara*	28
Rosenberg, I. G.,	*Long Beach*	10
Rosenberg, M. N.,	*Los Angeles*	10
Rosenberg, M. W.,	*Los Angeles*	10
Rosenberger, H. G.,	*Whittier*	10
Rosenblatt, J.,	*Duarte*	10
Rosenbloom, D.,	*Los Angeles*	10
Rosenblum, D. H.,	*Los Angeles*	10
Rosenblum, H. H.,	*San Francisco*	23
Rosencrantz, E.,	*San Francisco*	23
Rosenfeld, M. H.,	*Los Angeles*	10
Rosenkranz, H. A.,	*Los Angeles*	10
Rosenthal, A. G.,	*San Francisco*	23
Rosenthal, A. M.,	*Los Angeles*	10
Rosove, L.,	*Santa Monica*	10
Ross, A.,	*Los Angeles*	10
Ross, D. E.,	*Los Angeles*	10
Ross, K. F.,	*Los Angeles*	10
Ross, M. H.,	*Los Angeles*	10
Ross, P.,	*Richmond*	3
Ross, S. G.,	*Pasadena*	10
Ross, V. R.,	*Stockton*	24
Rossi, F. J., Jr.,	*Fairfield*	32
Rosson, C. T.,	*Hanford*	8
Rosson, C. T., Jr.,	*Hanford*	8
Rosson, R. W.,	*Tulare*	36
Roth, A.,	*Brooklyn, N. Y.*	10
Roth, E. F.,	*Palo Alto*	28
Roth, H. A.,	*Long Beach*	10
Rothman, P. E.,	*Los Angeles*	10
Rothwell, W. T.,	*Los Angeles*	10
Rouff, E.,	*San Jose*	28
Rover, H. P.,	*Los Angeles*	10
Row, C. F.,	*Santa Monica*	10
Rowan, E. J.,	*Wilmington*	10
Rowe, A. H.,	*Oakland*	1
Rowe, M. J.,	*Norwalk*	10
Rowell, H. N.,	*Berkeley*	1
Rowell, W. A.,	*Trinity Center*	30
Royer, J. E.,	*Oakland*	1
Royston, E. A.,	*Los Angeles*	10
Rubenstein, C. L.,	*San Francisco*	23
Rubin, J. S.,	*Los Angeles*	10
Rubinstein, I.,	*Los Angeles*	10
Rubinstein, V. G.,	*Los Angeles*	10
Ruddock, J. C.,	*Los Angeles*	10
Ruddy, L. W.,	*Sacramento*	19
Rude, A. E.,	*Los Angeles*	10
Rue, H. A.,	*Los Angeles*	10
Ruediger, E. H.,	*San Diego*	22
Rueter, K.,	*Oakland*	1
Ruff, F. R.,	*Fresno*	4
Ruggles, H. E.,	*San Francisco*	23
Rukke, G. V.,	*Monterey*	14
Rukke, R. V.,	*Monterey*	14
Rulison, E. T.,	*Sacramento*	19
Rumph, P. E.,	*Orange*	16
Runckel, G. H.,	*McCloud*	31
Runner, J. F.,	*San Francisco*	23
Runyon, L. A.,	*Westwood*	9
Rupp, J. J.,	*Santa Barbara*	27
Rusche, C. F.,	*Hollywood*	10
Rush, R. C.,	*San Fernando*	10
Russell, E. L.,	*Santa Ana*	16
Russell, F. C.,	*San Diego*	22
Russell, J. A.,	*Auburn*	17
Russell, R.,	*Glendale*	10
Russell, T. C.,	*Tracy*	24
*Russell, W. W.,	*San Diego*	22
Ruth, E. S.,	*Hollywood*	10
Ruth, G. D.,	*Los Angeles*	10
Rutherford, F. de P.,	*Santa Clara*	28
Rutherford, M. H.,	*San Francisco*	23
Ryan, A. F.,	*Los Angeles*	10
Ryan, A. J.,	*Vallejo*	32
Ryan, A. M.,	*San Francisco*	23
Ryan, C. D.,	*Los Angeles*	10
Ryan, F. S.,	*San Jose*	28
Ryan, R. C.,	*San Francisco*	23
Ryan, W. J.,	*San Diego*	22
Ryder, B. E.,	*Los Angeles*	10
Rypins, R. F.,	*San Francisco*	23
Rytand, D. A.,	*San Francisco*	23

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NAME	CITY	COUNTY SOCIETY NO.
Saam, J. G.,	*Oakland*	1
Sabichi, G. C.,	*Claremont*	10
Saeltzer, D. V.,	*Sacramento*	19
Safarik, E. S.,	*Los Angeles*	10
Saffro, L. B.,	*San Pedro*	10
Saier, M. H.,	*Palo Alto*	28
Saint, J. H.,	*Santa Barbara*	27
Sale, J. J.,	*San Francisco*	23
Salisbury, C. S.,	*Los Angeles*	10
Salomon, E.,	*San Francisco*	23
Salomon, W.,	*Los Angeles*	10
Salter, N. M.,	*Williams*	38
Salvin, M.,	*Los Angeles*	10
Sambuck, A. J.,	*Watsonville*	29
Sample, T. N.,	*Fresno*	4
Sampson, J. A.,	*Los Angeles*	10
Sampson, J. J.,	*San Francisco*	23
Sampson, J. P.,	*Santa Monica*	10
Sampson, M. H.,	*Berkeley*	1
Sampson, P. M.,	*Long Beach*	10
Sampson, W. A.,	*San Francisco*	23
Samson, P. C.,	*Oakland*	1
Samuels, J. L.,	*Los Angeles*	10
Sanderson, G. H.,	*Stockton*	24
Sandholt, J. P.,	*Monterey*	14
Sandie, J.,	*Los Angeles*	10
Sands, R. A.,	*Santa Monica*	10
Sands, R. L.,	*Santa Monica*	10
Sands, R. L.,	*Santa Monica*	10
Sanford, H. E.,	*Montrose*	10
Sanford, J. R.,	*Pasadena*	10
Sansum, W. D.,	*Santa Barbara*	27
Sapiro, N. A.,	*Los Angeles*	10
Sappington, E. E.,	*San Francisco*	23
Sargent, W. H.,	*Oakland*	1
Sarkisian, M.,	*Sacramento*	19
Sartori, H. J.,	*San Francisco*	23
Sasso, J. A.,	*Los Angeles*	10
Satterlee, A. H.,	*Lompoc*	27
Satterlee, W. C.,	*San Diego*	22
Sauber, I. E.,	*Los Angeles*	10
Sauer, F. J.,	*Los Angeles*	10
Sauer, F. K.,	*Los Angeles*	10
Saunders, C. E.,	*Salinas*	28
Savage, J. C.,	*Los Angeles*	10
Savage, P. M.,	*San Bernardino*	21
Savage, P. M., Jr.,	*San Bernardino*	21
Savage, S. H.,	*Solano Beach*	10
Savage, W. W.,	*San Bernardino*	21
Saverien, A. E.,	*Los Angeles*	10
Saverien, H. L.,	*Sacramento*	19
Sawtelle, H. F.,	*Arroyo Grande*	25
Sawyer, F. E.,	*Oakland*	1
Sawyer, L.,	*San Francisco*	23
Saxon, A.,	*Los Angeles*	10
Saylin, G. J.,	*Los Angeles*	10
Saylin, J.,	*Santa Monica*	10
Saylor, B. F.,	*Redding*	30
Scamell, J. W.,	*Oakland*	1
Scanland, J. M.,	*Imola*	15
Scanlon, W. G.,	*Pasadena*	10
Scarboro, E. R.,	*Fresno*	4
Scarborough, R. A.,	*San Francisco*	23
Scatena, F. N.,	*Sacramento*	19
Schaefer, J. H.,	*Sacramento*	10
Schaefer, J. W.,	*Los Angeles*	10
Schaeffer, R. W.,	*Redondo Beach*	10
Schaller, W. F.,	*San Francisco*	23
Schallig, D. W.,	*Sacramento*	19
Schaper, E. A.,	*San Francisco*	7
Schatz, M. M.,	*Fresno*	4
Schaupp, K. L.,	*San Francisco*	23
Schefcik, J. F.,	*Los Angeles*	10
Scheier, R. B.,	*San Francisco*	23
Schell, J. P.,	*San Jose*	28
Schenck, G. F.,	*Los Angeles*	10
Schenk, H. L.,	*Los Angeles*	10
Schield, E. LeR.,	*Pomona*	10
Schiff, H.,	*Hollywood*	10
Schiff, M. J.,	*Los Angeles*	10
Schiff, W.,	*San Francisco*	23
Schiffbauer, H. E.,	*Los Angeles*	10
Schilling, C. F.,	*Pacific Grove*	14
Schilling, W.,	*San Francisco*	23
Schlageter, H. J.,	*San Francisco*	23
Schlappl, J. C.,	*San Diego*	22
Schlappi, R. F.,	*Hilt*	31
Schlesinger, E. R.,	*Los Angeles*	10
Schlotthauer, H. L.,	*Tehachapi*	7
Schlotthauer, M. Q.,	*Tehachapi*	7
Schluter, H. F.,	*Sacramento*	19
Schmelz, C. J.,	*Guerneville*	33
Schmerl, E. F.,	*Oakland*	1
Schmid, C. F.,	*Hermosa Beach*	10
Schmidt, A. E.,	*San Francisco*	23
Schmidt, A. R.,	*Los Angeles*	10
Schmidt, A. S.,	*Los Angeles*	10
Schmidt, D. A.,	*Los Angeles*	10
Schmidt, D. G.,	*San Quentin*	11
Schmidt, E. J.,	*Fresno*	4
Schmidt, F. M.,	*Los Angeles*	10
Schmidt, P. E.,	*Glendale*	10
Schmitt, E. O. G.,	*San Jose*	28
Schmitt, H. H.,	*Gilroy*	28
Schmitt, L. S.,	*San Francisco*	23
Schmoele, J. M.,	*Los Angeles*	10
Schneider, E. G.,	*San Francisco*	23
Schneider, E. H.,	*Los Angeles*	10
Schneiders, R. A.,	*San Diego*	22
Schoff, C. E.,	*Sacramento*	19
Schofield, R. O.,	*Sacramento*	19
Scholl, A. J.,	*Los Angeles*	10
Scholtz, J. R.,	*Los Angeles*	10
Scholz, A. M.,	*Los Angeles*	10
Schomaker, T. P.,	*San Francisco*	23
Schoonmaker, G. D.,	*San Francisco*	23
Schott, H. J.,	*Los Angeles*	10
Schottstaedt, E. R.,	*Fresno*	4
Schottstaedt, W. E. R.,	*Fresno*	4
Schreiber, L. W.,	*Beverly Hills*	10
Schreiber, J.,	*Stockton*	24
Schriber, P. W.,	*Atwater*	13
Schroeder, F. B.,	*San Diego*	22
Schroeder, M. C.,	*Loma Linda*	21
Schroeder, R. L.,	*Alhambra*	10
Schroer, W. J.,	*Orange*	16
Schueler, L. A.,	*Beverly Hills*	10
Schuetz, C. E.,	*Hollywood*	10
Schultz, C. E.,	*Castroville*	14
Schultz, E.,	*Stanford University*	28
Schultz, H. H.,	*San Francisco*	23
Schultz, L. O.,	*Glendale*	10
Schulz, R. L.,	*Los Angeles*	10
Schulze, M.,	*San Francisco*	23
Schumacher, I. C.,	*San Francisco*	23
Schurmeier, H. L.,	*Santa Barbara*	27
Schussler, H., Jr.,	*San Francisco*	23
Schwalenberg, H. R.,	*Santa Barbara*	27
Schwartz, A. H.,	*Beverly Hills*	10
Schwartz, A. J.,	*San Anselmo*	11
Schwartz, D. Z.,	*Los Angeles*	10
Schwartz, F. L.,	*San Diego*	22
Schwartz, I.,	*San Francisco*	23
Schwarz, J.,	*San Francisco*	23
*Schwarz, T. E.,	*Oakland*	1
Schwing, H. E.,	*Standard City*	24
Schwuchow, W. B.,	*Los Angeles*	10
Sciaroni, G. H.,	*Fresno*	4
Scobee, J. E.,	*Los Angeles*	10
Scoins, W. H.,	*Los Angeles*	10
Scott, A. J., Jr.,	*Los Angeles*	10
Scott, F. L.,	*Los Angeles*	10
Scott, J. T.,	*San Diego*	22
Scott, R. R.,	*Selma*	4
Scott, W. E.,	*San Francisco*	23
Scovel, R. E.,	*San Francisco*	23
*Scribner, R. G.,	*Sacramento*	19
Scroggy, J. Q. A.,	*Los Angeles*	10
Scudder, R.,	*Fort Bragg*	12
Scuderi, S. A.,	*Los Angeles*	10
Seabolt, G. C.,	*South Pasadena*	10
Seals, P. W.,	*Los Angeles*	10
Seapy, L. F.,	*San Francisco*	23
Searls, H. H.,	*San Francisco*	23
Seaver, H. C.,	*Los Angeles*	10
Seavey, M. A.,	*Sacramento*	19
Sebastian, C. F.,	*Los Angeles*	10
Sedgwick, V. de M.,	*Long Beach*	10
Seeburt, E. M. P.,	*San Francisco*	23
Seech, S. G.,	*Los Angeles*	10
Seeley, L. J.,	*Whittier*	26
Seeley, P. A.,	*Burlingame*	26
Segall, G.,	*Los Angeles*	10
Seibel, J. J.,	*Lodi*	24
Seiberth, J.,	*Pixley*	36
Seid, M. J.,	*San Francisco*	23
Seiger, H. W.,	*Ocean Park*	21
Seitz, R. P.,	*San Francisco*	23
Sekiyama, I.,	*Los Angeles*	10
eletz, E.,	*Los Angeles*	10
Seletz, R.,	*Los Angeles*	10
Seligman, L. J.,	*Dinuba*	36
Seligman, L. J.,	*Los Angeles*	10
Sellery, A. C.,	*Long Beach*	10
Sellery, C. M.,	*Los Angeles*	10
Sellew, P. K.,	*Los Angeles*	10
Sellon, G. I.,	*Fullerton*	16
Semenov, H.,	*Beverly Hills*	10
Senseman, W. R.,	*Lancaster*	10
Servin, C.,	*Los Angeles*	10

NAME	CITY	COUNTY SOCIETY NO.
Settle, F. B.	*Long Beach*	10
Setzler, G. B.	*Los Angeles*	10
Sevenman, G. W.	*San Mateo*	26
Sevier, E.	*Sacramento*	19
Sewall, E. C.	*San Francisco*	23
Seymour, E. C.	*Olive View*	10
Shackford, B. C.	*Long Beach*	10
Shade, M. A.	*Oakland*	1
Shafer, F. P.	*Los Angeles*	10
Shaffer, C. J.	*Huntington Park*	10
Shafor, H. A.	*Los Angeles*	10
Shaghoian, A. H.	*Daly City*	26
Shahovitch, G. P.	*Los Angeles*	10
Shambaugh, N. F.	*Long Beach*	10
Shanks, H. J.	*Pleasanton*	1
Shanley, F. D.	*Oakland*	1
Sharp, G. S.	*Pasadena*	10
Sharp, J. C.	*Salinas*	14
Sharp, J. G.	*San Francisco*	23
Sharp, K. F.	*Fresno*	4
Sharp, R. G.	*San Diego*	22
Sharpe, O. A.	*San Francisco*	26
Sharpsteen, J. R.	*Oakland*	1
Shattuck, H. P.	*Los Angeles*	10
Shaull, E. M.	*Palo Alto*	28
Shaw, E. B.	*San Francisco*	23
Shaw, H. N.	*Los Angeles*	10
Shaw, L. O.	*Walnut Park*	10
Shea, J. F.	*San Francisco*	23
Shea, J. J.	*San Diego*	22
Shea, T. T.	*San Francisco*	23
Sheafe, E. V.	*Oakland*	1
Sheehy, F. T.	*San Francisco*	23
Sheets, O. B.	*Los Angeles*	10
Sheets, W. T.	*W. Los Angeles*	10
Shefoff, H. A.	*Oakland*	1
Shelby, D. C.	*Los Angeles*	10
Sheld-Ritchie, I.	*Riverside*	18
Sheldon, E. A.	*Bellflower*	10
Sheldon, E. C.	*Hollister*	20
Sheldon, E. F.	*Los Angeles*	2
Sheldon, F. B.	*Pasadena*	10
Sheldon, R. F.	*Long Beach*	10
Sheller, W. O.	*Long Beach*	10
Shelton, E. K.	*Los Angeles*	10
Shelton, G. C.	*Los Angeles*	10
Shelton, V. G.	*Hollywood*	10
Shenk, F. P.	*Santa Cruz*	29
Shepard, C. E.	*Los Altos*	28
Shepard, W. P.	*San Francisco*	23
Shepardson, D. E.	*San Francisco*	23
Shepardson, H. C.	*San Francisco*	23
Shephard, J. H.	*San Jose*	28
Shepherd, H. L.	*Los Angeles*	10
Sher, B. H.	*Los Angeles*	10
Sheranian, H. N.	*Los Angeles*	10
Sherman, B. H.	*Hollywood*	10
Sherman, J.	*San Francisco*	23
Sherman, R. S.	*San Francisco*	23
Sherrard, E. E.	*Los Angeles*	10
Sherrick, J. W.	*Oakland*	1
Sherrill, J. W.	*La Jolla*	22
Sherry, L. B.	*Pasadena*	10
Shields, L.	*Oakland*	1
Shiels, G. F.	*Redwood City*	26
Shilling, J. W.	*Los Angeles*	10
Shimkin, L.	*San Francisco*	23
Shipley, R. E.	*Los Angeles*	10
Shipley, W. C.	*Santa Rosa*	33
Shipman, S. J.	*San Francisco*	23
Shippey, R. H.	*Long Beach*	10
Shirey, C. W.	*North Hollywood*	10
Shoemaker, H.	*Los Angeles*	10
Shone, L. B.	*San Francisco*	23
Shook, F. M.	*Oakland*	1
Shore, F. A.	*Ventura*	37
Shore, S.	*Los Angeles*	10
Shorkley, T. M.	*Carpinteria*	27
Short, J. E.	*Los Angeles*	10
Shreck, J. A.	*Redlands*	21
Shryock, A.	*Loma Linda*	21
Shryock, E. H.	*Loma Linda*	21
Shuck, C. H.	*Fresno*	4
Shufelt, A. A.	*San Jose*	28
Shulman, L.	*Los Angeles*	10
Shultz, E. L.	*Los Angeles*	10
Shumaker, E. K.	*Los Angeles*	10
Shumaker, P. R.	*Oakland*	1
Shumaker, P. W.	*Los Angeles*	10
Shuman, J. W.	*Los Angeles*	10
Shumate, C. A.	*New York, N. Y.*	23
Shumate, F. O.	*San Francisco*	23
Shumate, J. W.	*San Francisco*	23
Shumate, T. E.	*San Francisco*	23
Shutes, M. H.	*Oakland*	1
Sicherman, K. L.	*Los Angeles*	10
Sides, H. E.	*Huntington Park*	10
Siefert, A. C.	*Oakland*	1
Siegel, L. E.	*Beverly Hills*	10
Siegmund, F. W.	*Los Angeles*	10
Sigworth, D. C.	*Long Beach*	10
Sills, S. J.	*Los Angeles*	10
Silton, M. Z.	*Los Angeles*	10
Silver, B.	*Los Angeles*	10
Silverberg, M. H.	*San Francisco*	23
Silverman, D. J.	*Los Angeles*	10
Silvia, C. A.	*Gilroy*	28
Simmons, H. M.	*Willows*	38
Simms, J. S.	*Bellflower*	10
Simon, J.	*Los Angeles*	10
Simons, C. G.	*No. Hollywood*	10
Simonds, P. E.	*Riverside*	18
Simpson, B.	*San Francisco*	23
Simpson, B. R.	*San Diego*	22
Simpson, L. E.	*Loma Linda*	21
Sinclair, A. D.	*San Francisco*	23
Singer, H.	*Los Angeles*	10
Singer, J. J.	*Los Angeles*	10
Singerman, I.	*Los Angeles*	10
Sink, W. D.	*Santa Maria*	27
Sipman, H. I.	*Oakland*	1
Sippy, J. J.	*Stockton*	24
Sirbu, A. B.	*San Francisco*	23
Sisson, C. E.	*Glendale*	22
Sisson, M.	*Oakland*	1
Skaff, J. E.	*San Francisco*	23
Skaleter, E. A.	*Los Angeles*	10
Skancky, A. O.	*San Bruno*	26
Skeel, D. W.	*Los Angeles*	10
Skelly, J. F.	*San Francisco*	23
Skelton, L. W.	*Pasadena*	10
Skillen, J.	*Olive View*	10
Skilling, L. E.	*Alameda*	1
Slagerman, V. B.	*Los Angeles*	10
Slater, H. M.	*Palo Alto*	28
Slater, V. G.	*San Bernardino*	21
Slattery, J. W.	*Mountain View*	28
Slaughter, H. C.	*Los Angeles*	10
Slavich, J. F.	*Oakland*	1
Slemons, J. M.	*Los Angeles*	10
Slepnikoff, S. F.	*San Francisco*	23
Sloan, L. E.	*Inglewood*	10
Sloan, L. N.	*Los Angeles*	10
*Sloan, O. J.	*Glendale*	10
Sloane, L. O.	*Los Angeles*	10
Slocum, Y. K.	*Northampton, Mass.*	10
Smale, G. A.	*Los Angeles*	10
Small, C. K.	*Oakland*	1
Small, C. S.	*Loma Linda*	21
Smallberg, H. E.	*W. Hollywood*	10
Smalley, R. B.	*Willits*	12
Smallwood, W. C.	*Long Beach*	10
Smart, E. P.	*Murphy*	24
Smart, R. H.	*Los Angeles*	10
Smedley, R. C.	*Los Angeles*	10
Smiley, H. W.	*Indio*	18
Smiley, K. E.	*Los Angeles*	10
Smitgen, P. H.	*Inglewood*	10
Smith, A. B.	*La Jolla*	22
Smith, A. E.	*Los Angeles*	10
Smith, A. M.	*Oakland*	1
Smith, B.	*Los Angeles*	10
Smith, B. H.	*Santa Monica*	10
Smith, B. H.	*Huntington Park*	10
Smith, C. E.	*San Francisco*	23
Smith, C. E.	*San Francisco*	23
Smith, C. L.	*Maywood*	10
Smith, C. R.	*Los Angeles*	10
Smith, D. A.	*Oakland*	23
Smith, D. D.	*Watsonville*	29
Smith, D. D.	*Birmingham, Ala.*	22
Smith, D. V.	*Long Beach*	10
Smith, E. D.	*Solvang*	27
Smith, E. G.	*Oakland*	1
Smith, E. W.	*San Francisco*	1
Smith, F. H.	*Salinas*	14
*Smith, F. H.	*San Bruno*	26
Smith, F. L.	*Colfax*	36
Smith, F. M.	*La Jolla*	22
Smith, G. F.	*Los Angeles*	10
Smith, H. A.	*Whittier*	10
Smith, H. C.	*Glendale*	10
Smith, H. D.	*Pomona*	10
Smith, H. G.	*Palo Alto*	28
Smith, H. J.	*Oakland*	1
Smith, J. J.	*Beverly Hills*	10
Smith, J. J. H.	*Colton*	21
Smith, J. O.	*San Francisco*	23
Smith, J. R.	*Fresno*	4
Smith, K. B.	*Oakland*	1
Smith, L. D.	*Stockton*	24
Smith, L. E.	*Hollister*	20
Smith, L. E.	*San Bernardino*	21
Smith, L. W.	*Los Angeles*	10
Smith, M. H.	*Hollywood*	10
Smith, N. R.	*Monterey Park*	10
Smith, P. M.	*San Francisco*	23
Smith, R. D.	*San Pedro*	10
Smith, R. L.	*Santa Monica*	10
Smith, R. L.	*Pomona*	10
Smith, R. L. I.	*Pasadena*	10
Smith, R. M.	*Riverside*	18
Smith, R. N.	*Los Angeles*	10
Smith, R. T.	*Pomona*	10
Smith, R. T.	*Palo Alto*	28
Smith, S.	*Pasadena*	10
Smith, S. K.	*Oakland*	1
Smith, T. B.	*Wilmington*	10
Smith, W.	*Los Angeles*	10
Smith, W. B.	*Los Angeles*	10
Smith, W. B.	*San Francisco*	23
Smith, W. S.	*San Diego*	22
Smithies, H. R.	*Alameda*	1
Smolt, C. A.	*Ventura*	37
Smolt, L. P.	*Ventura*	37
Smylie, R. S.	*San Diego*	22
Smyth, F. S.	*San Francisco*	23
Smyth, J. H.	*Ukiah*	12
Smyth, M. H.	*Stockton*	24
Smyth, R. J.	*Cayucos*	25
Smythe, H.	*Stockton*	24
Sneden, C. M.	*Long Beach*	10
Snoddy, C. A.	*Vallejo*	32
Snook, H. J.	*Oakland*	1
Snow, H. L.	*San Pedro*	10
Snow, R. H.	*Santa Monica*	10
Snow, W. F.	*New York, N. Y.*	28
Snure, H.	*Los Angeles*	10
Snyder, A. D.	*Los Angeles*	10
Snyder, C. C.	*Pasadena*	10
Snyder, G. A.	*West Los Angeles*	10
Snyder, G. S.	*San Francisco*	23
Snyder, W. H.	*Hollywood*	10
Sobey, G. L.	*Paso Robles*	25
Soderstrom, E. M.	*Merced*	13
Sogemeier, E.	*San Mateo*	26
Soghor, S.	*Los Angeles*	10
Sohler, F. E.	*Healdsburg*	33
Sohler, F. E., Jr.	*Cloverdale*	33
Soiland, A.	*Los Angeles*	10
Sokol, L. I.	*Los Angeles*	10
Soley, M. H.	*San Mateo*	26
Solomon, W. O.	*Oakland*	1
Somerfield, H. A.	*San Francisco*	23
Somers, M. R.	*San Francisco*	23
Sommer, E. A.	*Chino*	21
Sonnenberg, A.	*San Francisco*	23
Sooy, D. W.	*San Francisco*	23
Soper, H. V.	*Los Angeles*	10
Soracco, C. V.	*Placerville*	19
Sorauf, B. M.	*Fresno*	4
Sorenson, E. J.	*Hollywood*	10
Sornsen, A. A.	*Los Angeles*	10
Sorsky, E. D.	*Fresno*	4
Sosnowski, K. C.	*Long Beach*	10
Soto-Hall, R.	*San Francisco*	23
Soucey, H. G.	*Fresno*	4
Soutar, R. G.	*Sacramento*	19
Southgate, P. T.	*Long Beach*	10
Sox, H. C.	*Palo Alto*	28
Spalding, C. A. H.	*Richmond*	3
Spalding, J. B.	*Richmond*	3
Spaulding, A. Q.	*Santa Barbara*	27
Spaulding, J. M.	*Los Angeles*	10
Spear, E. B.	*Los Angeles*	10
Spear, J. L.	*Santa Rosa*	33
Speer, G. G.	*Los Angeles*	10
Speik, F. A.	*Los Angeles*	10
Spencer, G. A.	*Sacramento*	19
Spencer, R. M.	*Los Angeles*	10
Sperling, S.	*Los Angeles*	10
Sperling, S. J.	*Los Angeles*	10
*Spiegel, M. J.	*Los Angeles*	10
Spier, C. A.	*Los Angeles*	10
Spiers, H. W.	*Los Angeles*	10
Spitalny, A.	*San Francisco*	23
Splithoff, C. A.	*Oakland*	1
Sprague, B. H.	*Los Angeles*	10
Sprague, G. T.	*Van Nuys*	10
Sprauer, V. J.	*Los Angeles*	10
Sproul, D. G.	*Berkeley*	23
Spruance, H. E.	*San Diego*	22
Staatz, A. D.	*Olive View*	10
Stabel, F.	*Redding*	30
Stadfield, C. G.	*Hollywood*	10
Stadler, E.	*San Jose*	28
Stadlinger, K. P.	*Burbank*	10
Stadtherr, E. F.	*San Francisco*	23
Stadtmuller, E. S.	*San Francisco*	23
Stafford, C. E.	*Los Angeles*	10
Stafford, D. D.	*Alameda*	1
Stafford, H. E.	*Oakland*	1
†Stahl, W. F.	*Los Angeles*	10
Stailey, H. D.	*Los Angeles*	10
Staley, P. A.	*Palm Springs*	18
Stallings, M.	*San Francisco*	23
Staniford, K. J.	*Fresno*	4
Stanley, L. L.	*San Rafael*	11
Stannard, A. N.	*Berkeley*	1
Stanton, E. H.	*Glendora*	10
Stanton, E. M.	*Santa Monica*	10
Stanton, F. E.	*Long Beach*	10
Stanton, R. H.	*Pasadena*	10
Starbird, G. A.	*King City*	14
Stark, B. W.	*Los Angeles*	23
Stark, J. H.	*Oakland*	1
Stark, M.	*Los Angeles*	10
Starr, H. E.	*Los Angeles*	4
Starr, R. W.	*Los Angeles*	10
Staub, J. S.	*San Jose*	28
Stauffer, M. L.	*Pittsburg*	3
St. Clair, F. P.	*San Francisco*	23
Stealy, C. L.	*San Diego*	22
Steddom, F. W.	*Los Angeles*	10
Steele, A. A.	*Los Angeles*	10
Steele, A. B.	*Santa Barbara*	27
Steele, E. H.	*Los Angeles*	10
Steele, J. T.	*Dunsmuir*	31
Steele, M. T.	*Los Angeles*	10
Steen, C. E.	*Brea*	16
Steen, E. J.	*Fullerton*	16
Steere, R. A.	*Downey*	10
Steffy, J. L.	*Santa Monica*	10
Stegeman, W.	*Crescent City*	5
Stein, C.	*Bellflower*	10
Stein, J. L.	*Albany*	1
Stein, W. F.	*Fresno*	4

NAME	CITY	COUNTY SOCIETY NO.
Steinberg, J.	*Los Angeles*	10
Steinberg, P.	*Hollywood*	10
Steinert, G.	*Isleton*	19
Steinman, M.	*Los Angeles*	10
Steinmetz, A. F.	*Hayward*	1
Steiss, C. F.	*San Francisco*	23
Stelhorn, A. F.	*Rosemead*	10
Stellar, R. W.	*Wilmington*	10
Stephens, B. M.	*Alameda*	1
Stephens, B. P.	*Oakland*	1
Stephens, H. B.	*San Francisco*	23
Stephens, J. S.	*Los Angeles*	10
Stephens, P. H.	*Los Angeles*	10
Stephens, W. B.	*Alameda*	1
Stephens, W. C.	*Pasadena*	10
Stephenson, H. A.	*San Francisco*	23
Stern, R. G.	*Los Angeles*	10
Stern, R. L.	*Los Angeles*	10
Steven, R. A.	*San Francisco*	23
Stevens, C. S.	*Santa Barbara*	27
Stevens, G. A.	*Los Angeles*	10
Stevens, G. M.	*Los Angeles*	10
Stevens, J. B.	*Los Angeles*	10
Stevens, W. E.	*San Francisco*	23
Stevens, W. L.	*Santa Monica*	10
Stevenson, A. P.	*Torrance*	10
Stevenson, C. C.	*Oakland*	1
Stevenson, G. L.	*Sacramento*	19
Stevenson, S. L.	*San Francisco*	23
Stewart, A. E.	*Los Angeles*	10
Stewart, C. M.	*Los Angeles*	10
Stewart, D. E.	*Huntington Park*	10
Stewart, H. B.	*Modesto*	34
Stewart, H. J.	*San Diego*	22
Stewart, R. A.	*San Francisco*	23
Stewart, S. F.	*Los Angeles*	10
Stewart, W.	*Los Angeles*	10
St. Geme, J. W.	*Los Angeles*	10
Stibbens, F. H.	*Oakland*	1
‡Stickler, J. H.	*Stewart, Nevada*	10
Stiles, F. E.	*San Francisco*	23
Stilson, G. D.	*Long Beach*	10
Stilson, W. L.	*Los Angeles*	10
Stilwell, L. E.	*Hollywood*	10
Stimson, C. A.	*Petaluma*	33
Stirewalt, H. W.	*Concord*	3
Stockton, A. B.	*San Francisco*	23
Stoddard, J. McC.	*Beverly Hills*	10
Stoddard, T. A.	*San Francisco*	23
Stoker, E. M.	*San Francisco*	23
Stoll, A. H.	*Oxnard*	37
Stolle, F.	*Dixon*	32
Stolz, C. E.	*Los Angeles*	10
Stolz, H. R.	*Berkeley*	1
Stone, B.	*San Francisco*	23
Stone, B. I.	*San Diego*	22
Stone, C. S.	*Santa Barbara*	27
Stone, E. M.	*Riverside*	18
Stone, R. S.	*San Francisco*	23
Stone, W. J.	*Pasadena*	10
Stookey, L. J.	*San Francisco*	23
Stoops, R. P.	*Oakland*	1
Storey, T. A.	*Stanford University*	28
Stork, V. E.	*Los Angeles*	10
Stoughton, A. V.	*Claremont*	10
Stout, G. T.	*Los Angeles*	10
Stout, K. L.	*San Francisco*	4
Stovall, L.	*Los Angeles*	10
Stowe, O. P.	*Oakland*	1
Stowe, W. P.	*San Francisco*	23
Strahlmann, L.	*San Diego*	22
Strang, T.	*Long Beach*	10
Strange, S. P.	*San Francisco*	23
Strange, V. M.	*San Francisco*	23
Stratford, E. B.	*Los Angeles*	10
Strathearn, H. J.	*Hollywood*	10
Stratton, E. K.	*San Francisco*	23
Stratton, G. W.	*Marysville*	39
Stratton, J. M.	*Berkeley*	1
Strauss, B.	*San Francisco*	23
Streaker, L. H.	*Goleta*	27
Strickler, D.	*San Francisco*	23
Strickler, J. P.	*San Francisco*	23
Striegel, L. McC.	*Long Beach*	10
Strietmann, W. H.	*Oakland*	1
Strong, A. J.	*Santa Paula*	37
Strongin, S.	*Bakersfield*	7
Strouse, S.	*Los Angeles*	10
Struble, H. P.	*Hayward*	1
St. Sure, F. A.	*San Diego*	22
Stump, F. M.	*Crescent City*	5
Sturdivant, B. F.	*Pasadena*	10
Sturgeon, C. T.	*Los Angeles*	10
Sturges, R. L.	*Los Angeles*	10
Sudlow, E. L.	*San Fernando*	10
Suehs, P. E.	*San Francisco*	23
Sugar, E. L.	*Beverly Hills*	10
Sugar, H.	*Los Angeles*	10
Suglian, V. V.	*San Francisco*	23
Sullivan, C. S.	*San Jose*	28
Sullivan, D. F.	*Pasadena*	10
Sullivan, J. J.	*Oakland*	1
Sullivan, J. M.	*San Francisco*	23
Sullivan, J. R.	*San Francisco*	23
Sullivan, N. R.	*Santa Cruz*	29
Sullivan, W.	*Dos Palos*	13
Sullivan, W. A.	*Ontario*	21
Sullivan, W. J.	*Hollywood*	10
Sulzbacher, C. I.	*Los Angeles*	10

NAME	CITY	COUNTY SOCIETY NO.
Sumerlin, H. S.	*San Diego*	22
Sumner, W. A.	*San Francisco*	23
Sundberg, R. H.	*San Diego*	22
*Sundin, P. O.	*Los Angeles*	10
Sunzeri, A. T.	*San Jose*	28
Surber, A. C., Jr.	*Los Angeles*	10
Suski, P. M.	*Los Angeles*	10
Susnow, D. A.	*San Francisco*	23
Sutherland, K. H.	*Santa Ana*	16
Sutherland, P. R.	*Los Angeles*	10
Sutherland, R. T.	*Oakland*	1
Sutherlin, C. G.	*Los Angeles*	10
Sutton, T. L.	*Stockton*	24
Svoboda, F. C.	*San Diego*	22
Swanson, C. F.	*Los Angeles*	10
Swarts, R. E.	*Hartford, Conn.*	26
Swauger, L. S.	*Oakland*	1
Swearingen, F. C.	*Pomona*	10
Sweeney, A. H.	*Fresno*	4
Sweeney, J. P.	*Millbrae*	26
Sweet, C. D.	*Oakland*	1
Sweetser, G. W.	*Martinez*	3
Sweigert, C. F.	*San Francisco*	23
Swengel, W. F.	*Monterey*	14
Swenson, B. I.	*Oakland*	1
Swenson, R. T.	*Van Nuys*	10
Swett, W. F.	*San Francisco*	23
Swezey, S.	*Los Angeles*	10
Swift, L. M.	*Marysville*	39
Swigart, M.	*Monterey*	14
Swim, W. A.	*Los Angeles*	10
*Swindt, J. M.	*Pomona*	10
Swinney, R. W.	*Long Beach*	10
Syman, L. W.	*Los Angeles*	10
Symonds, C. W.	*Pasadena*	10
Szukalski, J. P.	*Pasadena*	10

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NAME	CITY	COUNTY SOCIETY NO.
Taber, K. W.	*Pasadena*	10
Taber, L. E.	*San Francisco*	23
Tager, B. N.	*West Los Angeles*	10
Taggart, M. M.	*McFarland*	7
Talmage, C. H.	*Sanitarium*	15
*Taltavall, W. A.	*Redlands*	21
Tandowsky, R. M.	*Hollywood*	10
Tanaka, R. K.	*San Diego*	22
Tanner, C. O.	*San Diego*	22
Tarnutzer, B. C.	*Los Angeles*	10
Tarr, E. M.	*Los Angeles*	10
Tarr, L. N.	*Taft*	7
Tatro, R. F.	*San Bernardino*	21
Tattersall, K. L.	*Oakland*	1
Taubles, G. H.	*San Francisco*	23
Taussig, L.	*San Francisco*	23
Taylor, C. M.	*Los Angeles*	10
Taylor, D. A.	*San Francisco*	23
Taylor, E. C.	*San Francisco*	23
Taylor, E. M.	*Oakland*	1
Taylor, F. B.	*Oakland*	1
Taylor, F. W. H.	*Los Angeles*	10
Taylor, G. M.	*Los Angeles*	10
Taylor, J. C. W.	*San Rafael*	11
Taylor, L. E.	*Los Angeles*	10
Taylor, L. H.	*Oakland*	1
Taylor, L. M.	*San Bernardino*	21
Taylor, P. A.	*San Francisco*	23
Taylor, R. B.	*San Francisco*	23
Taylor, R. G.	*Los Angeles*	10
Taylor, R. N.	*Long Beach*	10
Taylor, R. O.	*San Diego*	22
Taylor, R. T.	*Los Angeles*	10
Taylor, W.	*Martinez*	3
Teaby, W. L.	*Monterey*	14
Teall, R. C.	*Sacramento*	19
Teass, C. J.	*San Luis Obispo*	25
Tebbe, F. H.	*Oakland*	1
Tebbetts, H. B.	*Los Angeles*	10
Tebbetts, H. E.	*Whittier*	10
Tedstrom, M. K.	*Santa Ana*	16
Teel, A. W.	*Los Angeles*	10
Teeter, A. L.	*Oakland*	1
Teitler, M. H.	*San Francisco*	23
Telford, P. K.	*Los Angeles*	10
Temple, R. J.	*Los Angeles*	10
Templeton, H. J.	*Oakland*	1
Templeton, W. K.	*Riverside*	18
Tepper, G. B.	*Los Angeles*	10
Terrill, E. E.	*Los Angeles*	10
Terry, R. A.	*Long Beach*	10
Terry, W. I.	*San Francisco*	23
Thayer, L. E.	*Los Angeles*	10
Thebaut, W. M., Jr.	*Oakland*	1
Thelander, H. E.	*San Francisco*	23
Thelan, E.	*San Diego*	22
Thibodeau, J. A.	*San Francisco*	23
Thienes, C. H.	*Los Angeles*	10
Tholen, E. F.	*Los Angeles*	10
Thomas, B.	*Oakland*	1
Thomas, B. S.	*Sacramento*	19
Thomas, E. W.	*Colton*	21
Thomas, G. F.	*Camarillo*	12
Thomas, H. S.	*Santa Cruz*	29
Thomas, R. E.	*Los Angeles*	10
Thomas, V. E.	*Pasadena*	10
Thomas, W. C.	*Long Beach*	10
Thomas, W. McL.	*San Diego*	22
Thomason, G.	*Los Angeles*	10
Thomason, S. D.	*San Dimas*	10

NAME	CITY	COUNTY SOCIETY NO.
Thompson, A. C.	*Mountain View*	28
Thompson, A. R.	*Rio Vista*	32
Thompson, C. P.	*San Francisco*	23
Thompson, C. V.	*Pescadero*	26
Thompson, C. V.	*Lodi*	24
Thompson, C. W.	*Pasadena*	10
Thompson, D. E.	*Red Bluff*	35
Thompson, E. E.	*Red Bluff*	35
Thompson, E. H.	*Burbank*	10
Thompson, H. A.	*San Diego*	21
Thompson, H. D.	*Los Angeles*	10
Thompson, H. F.	*Los Angeles*	10
Thompson, H. L.	*Los Angeles*	10
Thompson, H. L.	*Long Beach*	10
Thompson, I. B.	*Sonora*	24
Thompson, J. E.	*Los Angeles*	10
Thompson, K. J.	*Oakland*	1
Thompson, L. R.	*San Pedro*	10
Thompson, R. C.	*Whittier*	10
Thompson, R. H.	*Los Angeles*	10
Thompson, R. J.	*Los Angeles*	10
Thompson, R. L.	*Burbank*	10
Thompson, V. P.	*Los Angeles*	10
Thompson, W. B.	*Los Angeles*	10
Thompson, W. P.	*Los Angeles*	10
Thomson, A. M.	*Santa Rosa*	33
Thomson, D.	*Burbank*	10
Thomson, H. S.	*San Francisco*	23
Thomson, W. L.	*San Francisco*	23
Thoren, M. E.	*Weimar*	17
Thormann, J. A.	*Fresno*	4
Thorne, I. W.	*San Francisco*	23
Thorner, M.	*Santa Maria*	27
Thornton, A. J.	*San Diego*	22
Thorpe, A. C.	*Los Angeles*	10
Thorpe, F.	*Hollywood*	10
Threlfall, D. R.	*San Jose*	28
Thunen, P. E.	*Marysville*	39
Thurber, F.	*Hollywood*	10
Thurber, P.	*Los Angeles*	10
Thuresson, P. F.	*Riverside*	18
Thurlow, A. A.	*Santa Rosa*	33
Thurlow, J. F.	*Santa Rosa*	33
Tiber, L. J.	*Los Angeles*	10
Tice, E. W.	*Los Angeles*	10
Tickell, A. H.	*Nevada City*	17
Tidd, C. W.	*Los Angeles*	10
Tiffany, D. F. E.	*San Jose*	28
Tillman, F. J.	*Fresno*	4
Tillman, T. E.	*San Francisco*	23
Tillmanns, C. S. J.	*Los Angeles*	10
Tillotson, J. E.	*Colusa*	38
Tillotson, R. S.	*Sacramento*	19
Timme, A. R.	*Los Angeles*	10
Timon, A. N.	*Los Angeles*	10
Tipton, S. P.	*Watsonville*	29
Tirrell, W. M.	*Los Angeles*	10
Tisinger, E. L.	*San Bernardino*	21
Titcomb, L. R.	*Los Angeles*	10
Titus, C. I.	*Sacramento*	19
Titus, J. H.	*Ontario*	21
Tobias, E. B.	*San Francisco*	23
Tobias, M.	*Los Angeles*	10
Tobias, S. F.	*Grass Valley*	17
*Tobin, P. A.	*San Francisco*	23
Tock, E. W.	*Santa Ana*	16
Todd, J. B.	*Los Angeles*	10
Toffelmier, D. D.	*Oakland*	1
†Togasaki, K.	*San Francisco*	23
†Togasaki, T.	*San Francisco*	23
Toland, C. G.	*Los Angeles*	10
Tollefson, D. G.	*Los Angeles*	10
Toller, R. B.	*Talmage*	12
Tolman, G. P.	*Watsonville*	29
Toma, J. J.	*Los Angeles*	10
Tomblin, B. M. A.	*Los Angeles*	10
Tompkins, H. F.	*Santa Barbara*	27
Toomey, F. E.	*San Diego*	22
Topham, E.	*San Francisco*	23
Topping, F. P.	*Carmel*	14
Torbert, H. C.	*San Diego*	22
Torell, G. J.	*Los Angeles*	10
Torrano, M. A.	*Oakland*	1
Torre, E. D.	*San Francisco*	23
Torrens, A. S.	*Hanford*	8
Torrey, F. A.	*San Francisco*	23
Torrey, H. B.	*Oakland*	1
Totten, H. P.	*Los Angeles*	10
Tourtillot, W. W.	*Porterville*	36
Tow, J. E.	*San Diego*	22
Towne, E. B.	*San Francisco*	23
Townsend, C. E.	*Alhambra*	10
Townsend, K.	*Los Angeles*	10
Traber, C. H.	*Reedley*	4
Trainor, J. V.	*Los Angeles*	10
Trainor, M. E.	*Los Angeles*	10
Trauner, L. M.	*San Francisco*	23
Traver, C. M.	*Patton*	21
Trelstad, B. L.	*Redding*	30
Tretheway, L. E.	*Stockton*	24
Treweek, D. N.	*Los Angeles*	10
Trick, T. R.	*Stockton*	24
Trimble, H. G.	*Oakland*	1
Trimmer, E. L.	*Los Angeles*	10
Trott, L. d'N.	*Glendale*	10
Trotter, A. D.	*Los Angeles*	10
Troup, R. M.	*Berkeley*	1
Trowbridge, D. H., Jr.	*Fresno*	4
Truax, J. P.	*Lompoc*	27

NAME	CITY	COUNTY SOCIETY NO.
True, H. F.	*Sacramento*	19
Truman, S. R.	*Oakland*	1
Truxaw, J. W.	*Anaheim*	16
Tucker, G. E.	*Manhattan Beach*	10
Tucker, H.	*Agnew*	28
Tucker, M. B.	*Oakland*	1
Tucker, M. O.	*Ocean Park*	10
Tucker, R. G.	*Alhambra*	10
Tulley, F. E.	*San Diego*	22
Tully, J. J.	*Stockton*	24
Tunnell, A. M.	*Lodi*	24
Tunnell, P. J.	*Norwalk*	10
Tupper, R. B.	*Fresno*	4
Turbow, A. O.	*Los Angeles*	10
Turco, E. A.	*San Jose*	28
Turkel, A. S.	*Los Angeles*	10
Turley, J. G.	*Los Angeles*	10
Turnbull, F. M.	*Los Angeles*	10
Turner, E. C.	*Sacramento*	19
Turner, E. L.	*Los Angeles*	10
Turner, J. H.	*Huntington Park*	10
Tuteur, E. B.	*Los Angeles*	10
Tuttle, S.	*San Francisco*	23
Twitchell, E. W.	*San Francisco*	23
Tyerman, H. A.	*Needles*	21
Tyler, L. G.	*San Rafael*	11
Tyler, Y. C.	*Berkeley*	1
Tyroler, F. N.	*Los Angeles*	10
— U —		
Uhls, R. T.	*Long Beach*	10
Ullmann, H. J.	*Santa Barbara*	27
Ullrich, F. D.	*La Jolla*	22
Unsinger, H. F.	*San Francisco*	23
Updegraff, H. L.	*Hollywood*	10
Up de Graff, T. S.	*Pasadena*	10
*Upshaw, H. T.	*Pasadena*	10
Upton, J. R.	*San Francisco*	23
Ussher, N. T.	*Santa Barbara*	27
Utter, J. W.	*Anaheim*	16
Uyeyama, H.	*Oakland*	1
Uyeyama, K.	*San Francisco*	23
— V —		
Vachout, M. A.	*Southgate*	10
Vallee, J. E.	*Van Nuys*	10
Van Allen, L. K.	*Ukiah*	12
Vance, H. W.	*Pasadena*	10
Vance, J. T.	*Sacramento*	19
Van Cleve, M.	*Redlands*	21
Van Cott, W. B.	*Los Angeles*	10
Van Dalsem, S. B.	*San Jose*	28
Van Dalsem, W. S.	*San Jose*	28
Van Den Berg, W. J.	*Sacramento*	19
Van de Carr, F. R.	*Oakland*	1
Vanderburgh, C. M.	*Fresno*	4
Van de Pol, A.	*Modesto*	34
Van der Leek, P.	*Stockton*	24
Van Deventer, W. C.	*Redwood City*	23
Vandevert, G. V.	*Oakland*	1
Van Doren, B. J.	*Laguna Beach*	16
Van Dyke, H. M.	*Long Beach*	10
Van Eman, O. H.	*El Centro*	6
Van Fleet, H. D.	*Los Angeles*	10
Van Meter, A. L.	*Stockton*	24
Van Meter, F. J.	*Norwalk*	10
Van Nuys, R. G.	*Berkeley*	1
Van Ornum, E. N.	*Los Angeles*	10
Van Paing, J. F.	*Santa Barbara*	27
Van Pelt, R. S.	*Los Angeles*	10
Van Sciver, C. B.	*Los Angeles*	10
Van Scoyoc, J. G.	*Los Angeles*	10
Van Soest, E. H.	*Los Angeles*	10
*Van Vorhis, J. H.	*Corcoran*	8
Van Wagenen, R. J.	*Fresno*	4
Van Wart, R. M.	*West Los Angeles*	10
Van Zandt, V.	*Los Angeles*	10
Varden, A. E.	*San Bernardino*	21
Vardon, C. C.	*Oakland*	1
Vardon, E. M.	*Los Angeles*	10
Vargas, R. A.	*San Bernardino*	21
Vaughan, L. B.	*Long Beach*	10
Vaughn, J. O.	*Santa Monica*	10
Veach, H. O.	*Los Angeles*	10
Vecki, M. E.	*San Francisco*	23
Vener, H. I.	*Los Angeles*	10
Vento, J. P.	*Los Angeles*	10
Venzke, H.	*Pasadena*	10
*Veon, J. E.	*Bakersfield*	7
Verbryck, G. G.	*Long Beach*	10
Verne, V. E.	*Long Beach*	10
Viau, B. H.	*Sanger*	4
Vickerson, J. I.	*Oakland*	1
Vidgoff, I. J.	*Los Angeles*	10
Vidrickson, H. L.	*Weed*	31
Viecelli, J. D.	*San Francisco*	23
Vieira, E.	*Sebastopol*	33
Vieira, F. G.	*Stockton*	24
Vincent, G. P.	*San Francisco*	23
Vinetz, J. C.	*Los Angeles*	10
Vinks, W. A.	*Philadelphia, Pa.*	17
Viole, P. P.	*Los Angeles*	10
Violett, C. C.	*Garden Grove*	16
Visalli, J.	*San Francisco*	23
Visscher, L. G.	*Los Angeles*	10
Vizzard, W. R.	*San Francisco*	23
Vogelman, J.	*San Jose*	28
Voight, C. E.	*San Francisco*	23
Vollert, A. J.	*San Francisco*	23
Vollmer, A. M.	*San Francisco*	23
Vollmer, H. W.	*Sanitarium*	15
von Briesen, H.	*Los Angeles*	10
Von der Lieth, H. O.	*San Francisco*	23
von Dessoneck, E. S.	*San Francisco*	23
von Geldern, C. E.	*Sacramento*	19
von Geldern, H.	*San Francisco*	23
Von Hagen, K. O.	*Los Angeles*	10
Von Hungen, A. P.	*Escalon*	34
von Wedelstaedt, B.	*Long Beach*	10
Voorhees, H. M.	*Los Angeles*	10
Voorsanger, W. C.	*San Francisco*	23
Vruwink, J.	*Los Angeles*	10
— W —		
Waddell, D. Q.	*Los Angeles*	10
Waddell, W. E.	*Los Angeles*	10
Wade, A. B.	*Santa Ana*	16
Wade, R. S.	*Santa Ana*	16
Wagner, A. F.	*Los Angeles*	10
Wagner, D. L.	*Fort Bragg*	12
Wagner, L. D.	*Pasadena*	10
Wagner, R. J.	*San Francisco*	23
Wagner, R. L.	*Hartford, Conn.*	23
Wagner, V. E.	*San Dimas*	10
Wahl, H. A.	*San Francisco*	23
Wahle, H.	*Oakland*	1
Wahlen, J. A.	*Montebello*	10
Wahrhaftig, M. J.	*Fresno*	4
Waitzfelder, F.	*Los Angeles*	10
Wald, H. A.	*So. San Francisco*	23
Wales, J. LeR.	*Long Beach*	10
Walker, A. W.	*Riverside*	18
Walker, B. F.	*Fresno*	4
Walker, C. A.	*San Francisco*	23
Walker, C. B.	*Los Angeles*	10
Walker, G. W.	*Fresno*	4
Walker, H. M.	*Los Angeles*	10
Walker, J. D.	*Los Angeles*	10
Walker, J. E.	*Long Beach*	10
Walker, J. R.	*Fresno*	4
Walker, P. J.	*Los Angeles*	10
Walker, R. A.	*Alhambra*	10
Walker, R. J.	*Oakland*	1
Walker, R. S.	*Oakland*	1
Walker, W. H.	*Willows*	38
Wall, H. W.	*Hollywood*	10
Wall, M. M.	*San Francisco*	23
Wallace, A.	*Los Angeles*	10
Wallace, A. F.	*Sacramento*	19
Wallace, C. T.	*Eureka*	5
Wallace, E. P.	*Los Angeles*	10
Wallace, J. A.	*Calipatria*	6
Wallace, W. E.	*Whittier*	10
Wallace, W. S.	*Orange*	16
Wallach, I. A.	*Los Angeles*	10
Wallendorf, L. H.	*Los Angeles*	10
Waller, L. M.	*Hollywood*	10
Wallerius, R. M.	*Sacramento*	19
Walsh, F. D.	*Oakland*	1
Walsh, J. F.	*Eureka*	5
Walter, F. J.	*San Diego*	22
Walters, C. M. C.	*Los Angeles*	10
Walters, H. S.	*San Luis Obispo*	25
Walters, P. R.	*Berkeley*	1
Walters, S. J.	*Glendale*	10
Walton, G. E.	*Oakland*	1
Walton, O. P.	*Ventura*	37
Walton, R. R.	*Linwood*	10
Warburton, J. A.	*Burlingame*	26
Ward, R.	*San Francisco*	23
Wardrip, B. H.	*San Jose*	28
Ware, E. R.	*Los Angeles*	10
Ware, J. G.	*Bakersfield*	27
Wargin, J. I.	*Los Angeles*	10
Warmer, C. A.	*Los Angeles*	10
Warner, H. E.	*Los Angeles*	10
Warner, O. H.	*San Diego*	22
Warnock, A. W.	*San Pedro*	10
‡Warnshuis, F. C.	*Boston, Mass.*	23
Warren, H. C.	*Belmont*	26
Warren, J. P.	*San Francisco*	23
Warren, J. W.	*Los Angeles*	10
Warren, J. W.	*National City*	22
Wartemberg, R.	*San Francisco*	23
Washburn, W. W.	*San Francisco*	23
Watanabe, L. M.	*San Jose*	28
Waters, G. W.	*San Jose*	28
Waters, M. A.	*Woodland*	38
Waters, P. S.	*Patton*	21
Waters, Z. O.	*San Francisco*	23
Watke, L. E.	*Tulare*	36
Watkins, L. H.	*Pasadena*	10
Watkins, W. E.	*Santa Ana*	16
Watson, A. R.	*Eureka*	5
Watson, F. R.	*San Mateo*	26
Watson, F. V.	*Hollywood*	10
Watson, H. G.	*San Francisco*	23
Watson, L. F.	*Los Angeles*	10
Watson, R. G.	*Oakland*	1
Watson, T.	*Sunnyvale*	28
Watt, R. H.	*Beverly Hills*	10
Watters, E. M.	*Santa Cruz*	29
Watters, H. G.	*Watsonville*	29
Waxman, A.	*Los Angeles*	10
Way, S. C.	*San Francisco*	23
Wayburn, E.	*San Francisco*	23
Wayland, C.	*San Jose*	28
Wayland, R. T.	*Glendale*	10
Wayte, E. W.	*Norwalk*	10
Wear, J. W.	*Palo Alto*	28
Weatherman, H. V.	*Santa Ana*	16
Weaver, C. H.	*Los Angeles*	10
Weaver, D. D.	*Oakland*	1
Webb, A. N.	*Los Angeles*	10
Webber, W. T.	*Long Beach*	10
Weber, A. L.	*Upland*	21
Weber, W. L.	*Los Angeles*	10
Weber, W. M.	*San Francisco*	23
Webster, D. P.	*Fresno*	4
Webster, G. M.	*Patton*	21
Webster, J. C.	*Los Angeles*	10
Webster, J. S.	*Mariposa*	13
Webster, R. R.	*San Francisco*	23
Weddle, R. P.	*Roseville*	17
Wedgewood, P. E.	*San Diego*	22
Weeks, A.	*San Francisco*	23
Weeks, C. L.	*Los Angeles*	10
Wehrly, J.	*Santa Ana*	16
Wehrly, W. S.	*Santa Ana*	16
Weil, S. N.	*Rodeo*	3
Weinberg, S. J.	*West Los Angeles*	10
Weinberg, S. L.	*Los Angeles*	10
Weinberger, J.	*San Diego*	22
Weiner, W. M.	*San Francisco*	23
Weiser, A. D.	*Los Angeles*	10
Weiskotten, W. O.	*San Diego*	22
Weiss, K. F.	*Visalia*	36
Weitkamp, A. H.	*Los Angeles*	10
Weizer, E. A.	*Oakdale*	34
Welbourn, L. S.	*Van Nuys*	10
Welbourn, M. A.	*Los Angeles*	10
Welbourn, P. M.	*Los Angeles*	10
Welch, E. H.	*Pomona*	10
Welch, S. H.	*Glendale*	10
Welcome, E. H.	*Downey*	10
Welfer, C. R.	*Los Angeles*	10
Weller, T. W.	*Oakland*	1
Wellman, O. F.	*San Pedro*	10
Wells, C. E.	*Woodlake*	36
Wells, E. W.	*Los Angeles*	10
Wells, G. D.	*Los Angeles*	10
Wells, J. T.	*San Diego*	22
Wells, M. C.	*Los Angeles*	10
Wells, R.	*Pasadena*	36
Wells, S. J.	*Sacramento*	19
Welpton, M. A.	*San Diego*	22
Welsh, O. A.	*Ventura*	37
Welti, L.	*Napa*	15
Wemple, E. L.	*Verdugo City*	10
Werden, D. H.	*San Diego*	22
Werlich, R. E.	*San Diego*	22
Werner, E. A.	*Los Angeles*	10
Werthmann, P. A.	*Gustine*	24
Weseman, R. J.	*Novato*	11
Wessels, A. L.	*Salinas*	14
Wessels, W. F.	*Los Angeles*	10
Wessly, W. D.	*Glendale*	10
Wesson, M. B.	*San Francisco*	23
West, F. D.	*Beaumont*	18
West, F. E.	*San Francisco*	23
West, H. F.	*Los Angeles*	10
West, J. H.	*San Francisco*	23
Westerhout, C. E.	*Brea*	16
Weston, F. P.	*Pasadena*	10
Weston, F. W.	*Tustin*	16
Westphal, H. G.	*Glendale*	10
Wetherill, G. G.	*San Diego*	22
Wetmore, C. T.	*Berkeley*	1
Wever, G. K.	*Stockton*	24
Weyrauch, H. M., Jr.	*San Francisco*	23
Whalen, J. F.	*Altadena*	10
Whalen, T. J.	*San Francisco*	23
Whalman, H. F.	*Los Angeles*	10
Wharton, C. G.	*Los Angeles*	10
Wheatley, W. G.	*Azusa*	10
Wheeler, H. D.	*Inglewood*	10
Wheeler, O. W.	*Riverside*	18
Wheells, J. M.	*Beverly Hills*	10
Whitaker, L. S.	*San Jose*	28
Whitcomb, E. L.	*Los Angeles*	10
White, A. S.	*San Francisco*	23
White, C. W.	*LaVerne*	10
White, H. A.	*Los Angeles*	10
White, H. L.	*Redding*	30
White, J. F.	*San Diego*	22
White, J. H.	*Chico*	2
White, L. F.	*Los Angeles*	10
White, M. D.	*Ontario*	21
White, P. G.	*Los Angeles*	10
White, R. E.	*Orange*	16
Whitecotton, G. O.	*San Francisco*	23
*Whitelock, T. S.	*San Diego*	22
Whitelock, T. S., Jr.	*San Diego*	22
Whiting, E. G.	*Berkeley*	1
Whiting, F. M.	*Oroville*	2
Whitlow, J. E.	*Fillmore*	10
Whitmer, C. F.	*Colton*	21
Whitney, H. H.	*Burlingame*	26
Whitney, R. B.	*Yuba City*	39
Whitsett, J. W.	*Los Angeles*	10
Whittaker, L. F.	*Huntington Beach*	16
*Wickman, H. J.	*Riverside*	18
Wiebe, D.	*Reedley*	4
Wiebe, F. E.	*Salinas*	14

NAME	CITY	COUNTY SOCIETY NO.
Wiebusch, E. G. L.,	*Los Angeles*	10
Wiel, H. I.,	*San Francisco*	23
Wieman, W. H.,	*Los Angeles*	10
Wiens, F. L.,	*Porterville*	36
*Wiese, W. F.,	*Fresno*	4
Wightman, A. H.,	*Laguna Beach*	16
Wilbor, L. M.,	*San Francisco*	23
Wilbur, B. C.,	*Palo Alto*	28
Wilbur, D. L.,	*San Francisco*	23
Wilbur, R. L.,	*Stanford University*	23
Wilcox, A. B.,	*Santa Barbara*	27
Wilcox, C. F.,	*Huntington Park*	10
Wilcox, M. R.,	*Los Angeles*	10
Wilcox, R. W.,	*Long Beach*	10
Wilder, E. M.,	*Sacramento*	19
Wiley, E. H.,	*Los Angeles*	10
Wiley, H. J.,	*Huntington Park*	10
Wilhelm, L. F. X.,	*Los Angeles*	10
Wilhoit, J. W.,	*Ocean Beach*	22
Wilke, J. O.,	*Hermosa Beach*	10
Wilken, H. T.,	*Santa Monica*	10
Wilkinson, A. J.,	*National City*	22
Wilkinson, A. M.,	*Hollywood*	10
Willard, W. P.,	*San Francisco*	23
Willcutt, G. H.,	*San Rafael*	11
Willems, L. C.,	*Glendale*	10
Williams, A. B.,	*San Jose*	28
Williams, A. H.,	*Belmont*	26
Williams, A. J.,	*San Francisco*	23
Williams, A. W.,	*Los Angeles*	10
Williams, C. G.,	*Santa Monica*	10
Williams, D. B.,	*Colton*	21
Williams, D. B.,	*Veterans Home*	15
Williams, E. H.,	*Los Angeles*	10
Williams, F.,	*San Francisco*	23
Williams, F. F., Jr.,	*Patton*	21
Williams, H. D., Jr.,	*San Francisco*	23
Williams, J.,	*Eldridge*	33
Williams, J. B.,	*Los Angeles*	10
Williams, J. C.,	*San Francisco*	23
Williams, N. H.,	*Los Angeles*	10
Williams, P. M.,	*Los Angeles*	10
Williams, W.,	*Los Angeles*	10
Williams, W. F.,	*Oakland*	1
Williamson, M. A.,	*Lone Pine*	7
Williamson, M. C.,	*Upland*	21
Williamson, N. E.,	*Stockton*	24
Williamson, R. G.,	*Ontario*	21
Willier, A. F.,	*San Diego*	22
Willis, H. Q.,	*Balboa*	16
Willits, E. K.,	*San Francisco*	23
Willmott, A. C.,	*Los Angeles*	10
Wills, C. A.,	*Oakland*	1
Wills, I.,	*Santa Barbara*	27
Willson, L. R.,	*Fresno*	4
Wilmar, A. H.,	*Paso Robles*	25
Wilmeth, O. F.,	*Oakland*	1
Wilson, C.,	*Los Angeles*	10
Wilson, C. A.,	*Los Angeles*	10
Wilson, C. G.,	*Palo Alto*	28
Wilson, D. R.,	*San Jose*	28
Wilson, G.,	*Sacramento*	19
Wilson, G. W.,	*Los Angeles*	10
Wilson, H. F.,	*San Francisco*	23
Wilson, H. H.,	*Los Angeles*	10
Wilson, H. P.,	*Whittier*	10
Wilson, H. R.,	*Modesto*	34
Wilson, H. S.,	*N. Hollywood*	10
Wilson, J. B.,	*San Francisco*	23
Wilson, J. C.,	*San Jose*	28
Wilson, J. C.,	*Los Angeles*	10
Wilson, J. D.,	*Berkeley*	1
Wilson, J. M.,	*Pasadena*	10
Wilson, J. W.,	*San Francisco*	23
Wilson, J. W., Jr.,	*Los Angeles*	10
Wilson, L. E.,	*Anaheim*	16
Wilson, L. E.,	*San Francisco*	23
Wilson, K. R.,	*Santa Barbara*	27
Wilson, R. D.,	*Los Angeles*	10
Wilson, W. M.,	*Weaverville*	30
Wimmer, S. D.,	*Los Angeles*	10
Wimp, W. H.,	*Laguna Beach*	16
Wineberg, A. C.,	*Oakland*	1
Wineland, A. J.,	*Los Angeles*	10
Wing, L. A.,	*Eureka*	5
Winn, W. A.,	*Springville*	36
Winnard, W. F. R.,	*Los Angeles*	10
Winslow, A. L.,	*Oakland*	1
Winter, W. G.,	*Olive View*	10
Winterberg, W. H.,	*San Francisco*	23
Winternitz, C. D.,	*San Francisco*	23
Winters, W. P.,	*San Diego*	22
Wiper, T. B.,	*San Francisco*	23
Wirt, S. K.,	*Sunnyvale*	29
Wirth, R. G.,	*LaVerne*	10
Wise, D. C.,	*Pittsburg*	3
Wise, P. L.,	*San Jose*	28
Wisner, F. B.,	*Marysville*	39
Wissner, L. O.,	*Modesto*	34
Witherbee, H. R.,	*Los Angeles*	10
Witter, C. B.,	*Los Angeles*	10
Woelz, E.,	*San Francisco*	23
Wold, A. P.,	*Oakland*	1
Wolf, G. L.,	*San Francisco*	23
Wolfe, H. H.,	*Fort Bragg*	12
Wolff, E.,	*Los Angeles*	10
Wolff, E.,	*San Francisco*	23
Wolff, F. S.,	*San Francisco*	23
Wolff, M. J.,	*Los Angeles*	10
Wolfsen, L. H.,	*Modesto*	34
Wolfsohn, J. M.,	*San Francisco*	23
Wolfsohn, M.,	*Monterey*	14
Wolfson, I. E.,	*Los Angeles*	10
Wolpe, L. Z.,	*Los Angeles*	10
Woo, H. B.,	*San Francisco*	23
Wood, A. E.,	*Watsonville*	29
Wood, C. H.,	*Glendora*	10
Wood, C. L.,	*St. Helena*	15
Wood, D. A.,	*San Francisco*	23
Wood, D. A.,	*San Francisco*	23
Wood, F. W.,	*Alhambra*	10
Wood, G. J.,	*St. Helena*	15
Wood, G. N., Jr.,	*Palo Alto*	28
Wood, H. A.,	*Beaumont*	18
Wood, J. A.,	*Anaheim*	16
Wood, L. D.,	*Banning*	18
Wood, L. L.,	*Los Angeles*	10
Wood, O. T.,	*Red Bluff*	35
Wood, R. F.,	*National City*	22
Wood, W. A.,	*Oakland*	1
Woodard, D. S.,	*Watsonville*	29
Woodhull, C. G.,	*Los Angeles*	10
Woodhull, F. E.,	*Los Angeles*	10
Woodhull, R. A.,	*Los Angeles*	10
Woods, D. L.,	*Los Angeles*	10
Woods, L.,	*Oakland*	1
Woods, N. C.,	*Alhambra*	10
Woods, R. A.,	*Los Angeles*	10
Woolf, M. S.,	*San Francisco*	23
Woolfan, E. B.,	*Los Angeles*	10
Woolford, J. S.,	*Eureka*	5
Woolsey, C. H.,	*San Francisco*	23
Woolsey, J. H.,	*Woodland*	38
Woolston, W. J.,	*Pasadena*	10
Workman, R. A.,	*Pacific Grove*	14
Worster, W. W.,	*San Gabriel*	10
Worthington, L. C.,	*Bakersfield*	7
Worthington, R. L.,	*San Diego*	22
Wright, A.,	*Los Angeles*	10
‡Wright, B. W.,	*Nashville, Tenn.*	10
Wright, C. A.,	*Los Angeles*	10
Wright, J. M.,	*Pasadena*	10
Wright, K. D.,	*Santa Monica*	10
Wright, La V.,	*San Francisco*	23
Wright, R. W.,	*Palo Alto*	28
Wright, W. B., Jr.,	*Long Beach*	10
Wright, W. M.,	*Los Angeles*	10
Wright, W. R.,	*Los Angeles*	10
Wrigley, G. C.,	*Sonora*	24
Wrinkle, G. S.,	*Talmage*	12
Wyckoff, H. A.,	*San Francisco*	23
Wyers, R. E.,	*Spadra*	10
Wylie, C. A.,	*San Bernardino*	21
Wylie, C. R.,	*Ventura*	37
Wyne, P. S.,	*San Francisco*	23
Wynns, H. LeR.,	*Berkeley*	1

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NAME	CITY	COUNTY SOCIETY NO.
Yabroff, S. W.,	*Oakland*	1
Yaker, D. N.,	*Los Angeles*	10
Yamao, E.,	*Walnut Grove*	19
Yant, J. H.,	*Sacramento*	19
Yates, J. E.,	*Sacramento*	19
Yeagle, R. P.,	*Santa Ana*	16
Yee, J. J.,	*Oakland*	1
Yerxa, C. W.,	*Los Angeles*	10
Yoakam, F. A.,	*Moorpark*	37
Yocom, F. W.,	*San Luis Obispo*	25
Yoder, E. H.,	*Los Angeles*	10
Yoell, R. A.,	*San Francisco*	23
Yost, F. O.,	*Los Angeles*	10
Young, B. A.,	*Long Beach*	10
Young, C. S.,	*Los Angeles*	10
Young, D. D.,	*Santa Ana*	16
Young, E. L.,	*San Diego*	22
Young, E. N.,	*San Diego*	22
Young, F. B.,	*Long Beach*	10
Young, H. M.,	*San Diego*	22
Young, J. E.,	*Fresno*	4
Young, J. H.,	*San Diego*	22
Young, J. P.,	*Lemoore*	8
Young, J. W.,	*Beverly Hills*	10
Young, M. L.,	*North Hollywood*	10
Young, N. A.,	*Huntington Park*	10
Young, R. A.,	*Oakland*	1
Yuskis, A. S.,	*La Jolla*	22

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NAME	CITY	COUNTY SOCIETY NO.
Zaiser, H. E.,	*Orange*	16
Zanger, H. G.,	*San Jose*	28
Zantiny, W. G.,	*Long Beach*	10
Zeff, M. G.,	*Berkeley*	1
Zeiler, A. H.,	*Los Angeles*	10
Zeiler, J.,	*Los Angeles*	10
Zeimer, I. S.,	*Stockton*	24
Zelinsky, F.,	*Los Angeles*	10
Zeller, W. C.,	*Visalia*	36
Zelman, S.,	*Redlands*	21
Zide, H. A.,	*Los Angeles*	10
Zieber, R. L.,	*Santa Rosa*	33
Zimmerer, S. R.,	*Mecca*	18
Zimmerman, H.,	*Sacramento*	19
Zimmermann, W. T.,	*Los Angeles*	10
Zirkle, T. I.,	*Loma Linda*	21
Ziskind, E.,	*Los Angeles*	10
Ziskind, E. S.,	*Los Angeles*	10
Zobel, A. J.,	*San Francisco*	23
Zobel, J. F.,	*San Francisco*	23
Zochert, L. W.,	*La Mesa*	22
Zombro, F. B.,	*Los Angeles*	10
Zook, A. J.,	*Burbank*	10
Zorb, G. A.,	*Los Angeles*	10
Zukerman, S. N.,	*San Francisco*	23
Zukovich, G. E.,	*San Diego*	22
Zumwalt, E. R.,	*Tulare*	36
Zumwalt, F. H.,	*San Francisco*	23
Zumwalt, R. H.,	*San Francisco*	23

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II. ASSOCIATE MEMBERS

NAME	CITY	COUNTY SOCIETY NO.
Cummins, W. T.,	*San Francisco*	23
Leake, C. D.,	*San Francisco*	23
Rusk, G. Y.,	*San Francisco*	23
Weiss, C.,	*San Francisco*	23

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III. HONORARY MEMBERS

NAME	CITY	COUNTY SOCIETY NO.
*Harris, H.,	*San Francisco*	23
King, J. C.,	*Pasadena*	18
*Widney, Joseph P.,	*Los Angeles*	10

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IV. RETIRED MEMBERS

NAME	CITY	COUNTY SOCIETY NO.
Allen, F. M.,	*San Diego*	22
*Baker, F.,	*Point Loma*	22
Bennett, E. L.,	*Long Beach*	4
Bertola, M.,	*San Francisco*	23
Bogue, H. A.,	*Ontario*	21
Botsford, M. E.,	*San Francisco*	23
Brown, A.,	*San Francisco*	23
Browning, C. C.,	*Los Angeles*	10
Clark, J.,	*Gilroy*	28
Collins, A. W.,	*San Francisco*	23
Davis, B.,	*Los Gatos*	13
DePuy, E. S.,	*Oakland*	1
Derbyshire, A. L.,	*Sterling City*	2
Dillingham, F. S.,	*Los Angeles*	10
Dunsmoor, N. C.,	*Los Angeles*	10
Elliott, F. P.,	*San Diego*	22
Ely, L. W.,	*San Francisco*	28
Evans, G. H.,	*Berkeley*	23
Fairchild, C. H.,	*Woodland*	38
Fleming, E. W.,	*Los Angeles*	10
*Frederick, M. W.,	*Brentwood*	23
Fuller, R. N.,	*Tulare*	36
Gilbert, W. H.,	*Laguna Beach*	10
*Goodman, E.,	*San Francisco*	23
Graham, L.,	*Newberry*	21
Gunn, H.,	*Monticello*	10
Hablutzel, C. E.,	*San Jose*	28
Harbert, E.,	*Stockton*	24
Harvey, R. J.,	*Anaheim*	16
Henderson, J. J.,	*San Francisco*	23
Hogan, J. J.,	*Vallejo*	23
Houston, A. J.,	*Los Angeles*	23
Hyman, S.,	*Los Altos*	23
Jean, G. W.,	*St. Petersburg, Florida*	27
Kahn, A. J.,	*Los Angeles*	23
King, H. R.,	*Winters*	38
Kohlmoos, H. J.,	*Oakland*	1
La Fontaine, E. C.,	*San Francisco*	23
Leonard, A. T.,	*San Francisco*	23
Levison, C. C.,	*Sausalito*	23
Lindsay, W. K.,	*Sacramento*	19
Livingston, W. R.,	*Oxnard*	37
Lorini, R.,	*Paris, France*	22
MacDonald, E. A.,	*Beverly Hills*	21
MacLaughlin, W. E.,	*Los Angeles*	10
*McClenahan, H. C.,	*San Francisco*	23
McDaniel, J. L.,	*San Fernando*	10
McKee, A. B.,	*Redwood City*	23
McLellan, G. H.,	*San Diego*	22
McVey, C. L.,	*Oakland*	1
Meininger, L. L.,	*Palo Alto*	28
Melvin, J. T.,	*Porterville*	36
*Orbison, T. J.,	*Los Angeles*	10
Palmer, C. B.,	*Lagunitas*	23
Pope, E. W.,	*Carmel*	23
Porter, E. B.,	*San Diego*	22
Power, H.,	*Palo Alto*	28
Quinn, W.,	*San Francisco*	23
Rogers, F. L.,	*Long Beach*	10
Rothganger, G.,	*Oakland*	1
Shattinger, C.,	*Los Altos*	28
Shreck, J. A.,	*Redlands*	21
Siebe, E. B.,	*San Francisco*	23
*Simmons, G. C.,	*Inverness*	19
Smith, J. F.,	*San Francisco*	23
Somers, H.,	*Morgan Hill*	23
Spalding, A. B.,	*San Francisco*	23
Spiro, H.,	*San Francisco*	23
Spriggs, G. A.,	*San Mateo*	23
Taylor, M. C.,	*San Francisco*	24
Van Dalsem, W. S.,	*San Jose*	28
*Vecki, V. G.,	*San Francisco*	23
Waller, J. L.,	*San Francisco*	23
Ward, M. W.,	*San Francisco*	38
Waterman, H. J.,	*Berkeley*	23
*Weirich, E. W.,	*Angels Camp*	24
Welty, C. F.,	*San Francisco*	23
Whiffen, R. A.,	*San Jose*	28
Williams, E. H.,	*San Francisco*	23

NAME	CITY	COUNTY SOCIETY NO.
Winslow, T. H.	*Oakland*	1
Worthington, G. B.	*San Diego*	22
Yager, W. L.	*Los Angeles*	10
Yates, E. M.	*Santa Rosa*	33

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V. NEW MEMBERS SINCE JANUARY 1, 1939

(Jan. 1, 1939–March 1, 1939, inclusive)

NAME	CITY	COUNTY SOCIETY NO.
Abramson, A. J.	*San Francisco*	23
Allison, R. L.	*Los Angeles*	10
Alpert, D. S.	*Los Angeles*	10
Alsberge, M. A.	*Los Angeles*	10
Arnold, H. J.	*Palo Alto*	28
Attwood, C. J.	*Oakland*	1
Badami, A. F.	*San Jose*	28
Barr, J. A.	*Oakland*	1
Baus, G. J.	*Glendale*	10
Behm, M.	*San Francisco*	23
Belyea, J. H.	*Los Molinos*	35
Bennett, C. R.	*Camarillo*	37
Benveniste, R.	*Los Angeles*	10
Bergman, G. C.	*Fullerton*	16
Blackmun, E. L., Jr.	*Stockton*	24
Blak, E. V.	*San Francisco*	23
Blosmo, O. J.	*Los Angeles*	10
Blum, J.	*San Jose*	28
Bolstad, S. C.	*Hondo*	10
Bradbury, W. C.	*Los Angeles*	10
Branvh, C. H. H.	*Los Angeles*	10
Bravo, F.	*Los Angeles*	10
Bretthauer, C. G.	*Westwood Village*	10
Brewer, A. F.	*Fairfield*	32
Brignoli, W. H.	*St. Helena*	15
Brody, Y.	*San Francisco*	23
Brown, F. A.	*Auberry*	4
Budge, E. S.	*Los Angeles*	10
Buerger, L.	*Los Angeles*	10
Byrne, R. V.	*Los Angeles*	10
Carmody, J. P.	*Huntington Park*	10
Casey, E. A.	*Grass Valley*	17
Castanares, S.	*Los Angeles*	10
Clark, J. E.	*Oakland*	1
Coggin, C. B.	*Los Angeles*	10
Cole, M.	*Los Angeles*	10
Cooper, C. E.	*San Francisco*	23
Corlette, M. B.	*Pasadena*	10
Crawshaw, J. A.	*Hanford*	8
Cronenwett, P. H.	*Ripon*	34
Daniele, J. A.	*San Francisco*	23
Dassett, J. W.	*Whittier*	10
DeBusk, F. F. G.	*Visalia*	36
Delbridge, K. W.	*Pasadena*	10
Downs, V. S.	*Los Angeles*	10
Dygert, G. W.	*Oakland*	1
Eaton, A. C.	*San Francisco*	23
Edmeades, W. S.	*Martinez*	3
Edmondson, H. A.	*Pasadena*	10
Ehlers, B.	*Los Angeles*	10
Elerding, G. W.	*Los Angeles*	10
Finch, A. A.	*Pasadena*	10
Foulks, C. A.	*Long Beach*	10
Freytag, C. L.	*Oakland*	1
Fullenlove, T. M.	*Ventura*	37
Gamett, E. G.	*Weaverville*	30
Garfinkle, F. E.	*San Francisco*	23
Gerow, E. C.	*Lafayette*	3
Ginsberg, J.	*Los Angeles*	10
Godard, C. H.	*Los Angeles*	10
Gold, R. L.	*San Francisco*	23
Grant, L. C.	*Glendale*	10
Greeley, C. E.	*Inglewood*	10
Greeley, P. O.	*Inglewood*	10
Gump, M. E.	*San Diego*	22
Halburg, C. T., Jr.	*Redlands*	21
Hannon, L. J.	*Fullerton*	16
Hardin, R.	*Visalia*	36
Harker, R. K.	*Oxnard*	37
Harper, H. E.	*Los Angeles*	10
Henderson, E. E.	*San Francisco*	23
Hermann, C. A.	*Chino*	21
Higgins, I. W.	*Marysville*	39
Hillyer, C. C.	*Los Angeles*	10
Hollander, F. G.	*San Diego*	22
Hosmer, R. F.	*Beverly Hills*	10
House, L. R.	*Los Angeles*	10
Hughes, A. G.	*Santa Ana*	16
Humphreys, P. C.	*Los Angeles*	10
Hustead, E. L.	*Los Angeles*	10
Ireton, W. S.	*Tulare*	36
Jackson, E. R.	*Berkeley*	1
Johnson, J. B.	*Los Angeles*	10
Joldersma, R. D.	*Berkeley*	1
Jones, E. M.	*Los Angeles*	10
Jones, R. M.	*Ventura*	37
Kadesky, D.	*San Francisco*	23
Keenan, A. S.	*San Francisco*	23
Kelly, H. M.	*Riverside*	18
Kennedy, R. A.	*Hollywood*	10
King, S. D.	*Los Angeles*	10
Kinney, P. B.	*Pasadena*	10
Kirstensen, W. A.	*Los Angeles*	10
Knight, F. W.	*Corcoran*	8
Knott, N. L.	*Coalinga*	4
Kraaymes, H. J.	*Berkeley*	1
Lapeyre, J. L.	*Los Angeles*	10
Lawrence, J. H.	*San Francisco*	23
Libby, R. G.	*Berkeley*	1
Linne, F. B.	*Los Angeles*	10
Long, S. F.	*San Francisco*	23
Lynch, J. M.	*Pasadena*	10
Maher, E. J.	*San Luis Obispo*	25
Marcus, J. H.	*Los Angeles*	10
Marquis, H. H.	*San Francisco*	23
Mathis, E. N.	*Riverside*	18
McClellan, M. C.	*Upland*	21
McLean, L. S.	*Riverside*	18
McWhorter, P.	*Los Angeles*	10
Mendelsohn, H. A.	*Altadena*	10
Mershon, H. F.	*Los Angeles*	10
Moffitt, J. A.	*Los Angeles*	10
Moore, R. L.	*Loyalton*	9
Morris, S. A.	*Marysville*	39
Mortensen, M. A.	*Santa Monica*	10
Movius, C. K.	*Los Angeles*	10
Mozar, H. N.	*Los Angeles*	10
Mullen, R. M.	*Pasadena*	10
Murphy, P.	*Hanford*	8
Neugarten, K.	*San Francisco*	10
Norberg, R. W.	*Kingsberg*	4
Nottage, H. P.	*Ontario*	21
Null, R.	*Inglewood*	10
O'Connor, J. P.	*Trona*	21
Ogden, J. C.	*Long Beach*	10
Ownby, J. J.	*San Francisco*	23
Parrett, O. S.	*Pasadena*	10
Pattison, A. C.	*Pasadena*	10
Pavlides, T.	*San Francisco*	23
Pawley, R. E.	*Indio*	18
Plannette, H.	*Whittier*	10
Pohlman, A. G.	*Los Angeles*	10
Potter, G. V.	*Oakland*	1
Proctor, D. T.	*Altadena*	10
Procsch, W.	*San Francisco*	23
Pruitt, W. C.	*Oakland*	1
Puthoff, T. C.	*San Bernardino*	21
Redus, K.	*Los Angeles*	10
Rogers, A. E. T.	*San Fernando*	10
Rogers, L.	*Whittier*	10
Romm, M. E.	*Beverly Hills*	10
Rosenberg, R.	*San Francisco*	23
Rosenvold, L. D.	*Los Angeles*	10
Safier, B.	*Agnew*	28
Saslaw, L. B.	*Stockton*	24
Savage, S. H.	*Solano Beach*	22
Sawyer, E. H.	*Rockport*	12
Scheffel, A. G.	*Los Angeles*	10
Schiff-Goldstein, A.	*Los Angeles*	10
Schubert, F. H.	*Los Angeles*	10
Scott, A. J.	*Los Angeles*	10
Scott, J. W.	*Colusa*	38
Shearer, M. C.	*Berkeley*	1
Sheley, N. W.	*Los Angeles*	10
Silverman, D. J.	*Los Angeles*	10
Silverthorn, J. R.	*Long Beach*	10
Smith, C. R.	*Berkeley*	1
Smith, J. L.	*Los Angeles*	10
Snedaker, J. F., Jr.	*Los Angeles*	10
Sox, E. D.	*Visalia*	36
Stafford, D. E.	*San Francisco*	23
Stahl, V. O.	*Ontario*	21
Stansbury, M. P.	*Vacaville*	32
Steckel, M. L.	*Los Angeles*	10
Tancredi, C.	*San Diego*	22
Tiedemann, I. D.	*Los Angeles*	10
Todd, E. B.	*Concord*	3
Tragerman, L. J.	*Los Angeles*	10
Tullar, A. G.	*North Hollywood*	10
Walker, L. M.	*Los Angeles*	10
Walker, S. J.	*Pico*	10
Ware, C. W.	*Altadena*	10
Watson, L. C.	*Long Beach*	10
Weinberg, H.	*Los Angeles*	10
Weiss, H.	*Los Angeles*	10
Welke, J. O.	*Hermosa Beach*	10
Westerhout, F. C.	*Manhattan Beach*	10
Whittaker, T. W.	*Los Angeles*	10
Wilson, W. A.	*Los Angeles*	10
Winn, A. A.	*Springville*	36
Witherbee, O. O.	*Los Angeles*	10
Wolf, R. W.	*San Francisco*	23
Wolfes, E.	*San Francisco*	23
Woodruff, R. P.	*Cotati*	33
Wortman, A. V.	*Pasadena*	10

In Memoriam

Deceased Members—Year 1938

NAME	CITY	COUNTY SOCIETY NO.
Abraham, Vestal Raul, October 10, 1938	*Long Beach*	10
Baker, Fred, May 16, 1938	*Point Loma*	22
Bishop, Thomas W., December 28, 1938	*Pasadena*	10
Bliss, Walter Parks, November 3, 1938	*Pasadena*	10
Blond, Harry Hyman, March 11, 1938	*Los Angeles*	10
Bowers, Paul E., February 15, 1938	*Los Angeles*	10
Brinckerhoff, Elmer Ellsworth, March 12, 1938	*Oakland*	1
Carpenter, Frank L., May 16, 1938	*Berkeley*	1
Clark, Edward Perry, September 5, 1938	*Los Angeles*	10
Crabtree, Winston Churchill, July 14, 1938	*San Diego*	22
Dickerson, Harry William, March 24, 1938	*San Diego*	22
Dillon, Edward Thomas, October 14, 1938	*Los Angeles*	10
Dundas, Robert C., November 20, 1938	*Los Angeles*	10
Fitzpatrick, Earl Berton, December 11, 1938	*Martinez*	3
Frederick, Marcus White, September 4, 1938	*Brentwood*	23
Freund, E., December 13, 1938	*Los Angeles*	10
Galbraith, George H., September 11, 1938	*Long Beach*	10
Gates, Mark Gorman, November 15, 1938	*Santa Monica*	10
Goodman, Emanuel, February 22, 1938	*San Francisco*	23
Hanlon, Edward Russell, June 24, 1938	*Los Angeles*	10
Harris, Henry, July 7, 1938	*San Francisco*	23
Hobdy, William Cott, December 26, 1938	*San Francisco*	23
Houghton, Arthur D., January 23, 1938	*San Fernando*	10
Hovde, Anders G., August 14, 1938	*Hollywood*	10
Hull, James Porterfield, July 22, 1938	*Stockton*	24
Jones, Wendell A., September 20, 1938	*Riverside*	18
Kilbourne, Norman J., January 16, 1938	*Los Angeles*	10
King, Joseph Millen, October 7, 1938	*Los Angeles*	10
Lancaster, Jesse Samuel, November 5, 1938	*Torrance*	10
Lando, Milton E., January 31, 1938	*Oakland*	1
Langdon, Samuel W. R., December 30, 1938	*Stockton*	24
Lepper, Lawrence E., September 18, 1938	*Los Angeles*	10
Loehr, Bert E., April 12, 1938	*San Jose*	28
Lopez, Ernesto A., February 1, 1938	*San Leandro*	1
Loveren, George S., February 3, 1938	*Santa Barbara*	27
Martin, John Perry, July 5, 1938	*Oakland*	1
McArthur, Peter R., April 5, 1938	*Los Angeles*	10
McClenahan, H. C., December 11, 1938	*San Francisco*	23
Meneray, Prince Albert, March 1, 1938	*Santa Rosa*	33
Merrill, Belle Ellingsen, July 6, 1938	*Oakland*	1
Montgomery, John L., January 24, 1938	*Mandovi, Wis.*	10
Montgomery, Mary F., August 30, 1938	*San Francisco*	23
Newcomb, Arthur Thurston, July 18, 1938	*Pasadena*	10
Nichols, Fred C., May 27, 1938	*Santa Monica*	10
O'Neill, Arthur Aloysius, March 2, 1938	*San Francisco*	23
Orbison, Thomas James, March 26, 1938	*Los Angeles*	10
Orr, Jane, August 19, 1938	*Oakland*	1
Petty, Charles Odell, November 17, 1938	*Fullerton*	16
Pierce, Sterling N., September 30, 1938	*Los Angeles*	10
Pindler, Louis Alden, October 9, 1938	*Los Angeles*	10
Potter, Clarence D., December 8, 1938	*San Francisco*	23
Putnam, Victor E., March 11, 1938	*San Francisco*	23
Rixford, Emmet, January 2, 1938	*San Francisco*	23
Russell, William Wallace, March 2, 1938	*San Diego*	22
Schwarz, Theodore E., August 4, 1938	*Oakland*	1
Simmons, Gustavus Crocker, August 8, 1938	*Inverness*	19
Scribner, Richard G., November 19, 1938	*Sacramento*	19
Sloan, Orville Joseph, April 30, 1938	*Glendale*	10
Smith, Frank Holmes, February 19, 1938	*San Bruno*	26
Spiegel, Maurice J., April 21, 1938	*Los Angeles*	10
Sundin, Peter O., November 29, 1938	*Los Angeles*	10
Swindt, Joseph Martin, June 9, 1938	*Pomona*	10
Taltavall, William A., December 22, 1938	*Redlands*	21
Tobin, Peter Arthur, November 21, 1938	*San Francisco*	23
Upshaw, Harry Thomas, August 11, 1938	*Pasadena*	10
Van Vorhis, James H., February 9, 1938	*Corcoran*	8
Vecki, Victor G., November 16, 1938	*San Francisco*	23
Veon, John E., January 12, 1938	*Bakersfield*	7
Weirich, Elmer W., November 20, 1938	*Angels Camp*	24
Whitelock, Thomas S., May 25, 1938	*San Diego*	22
Wickman, Herman John, September 29, 1938	*Riverside*	18
Widney, Joseph P., July 4, 1938	*Los Angeles*	10
Wiese, Walter Fred, January 29, 1938	*Fresno*	4

PRESIDENTS OF THE CALIFORNIA MEDICAL ASSOCIATION

1856-1939

NAME	YEAR
*B. F. Keene	1856
*H. Gibbons, Jr.	1857
*A. B. Stout	1858
*R. B. Ellis	1859
No sessions (1859-1870)	
*T. M. Logan	1870
*H. Gibbons, Sr.	1871
*G. A. Shurtleff	1872
*T. H. Pinkerton	1873
*J. M. Browne	1874
*A. B. Nixon	1875
*William Fitch Cheney	1876
*Washington Ayer	1877
*H. S. Orme	1878
*A. W. Saxe	1879
*F. W. Todd	1880
*G. G. Tyrrell	1881
*L. C. Lane	1882
*L. E. Oatman	1883
*R. B. Cole	1884
*W. P. Gibbons	1885
*W. S. Thorne	1886
*R. H. Plummer	1887
*James Simpson	1888
*Walter Lindley	1889
*W. R. Cluness	1890
*O. O. Burgess	1891
*W. E. Taylor	1892
*C. G. Kenyon	1893
*G. L. Simmons	1894
*W. LeMoyne Wills	1895
*Henry Gibbons, Jr.	1896
*Cephas L. Bard	1897
*William Watt Kerr	1898
*George Chismore	1899
*Thomas Ross	1900
*William J. G. Dawson	1901
*F. B. Carpenter	1902
*H. Bert. Ellis	1903
*Frank L. Adams	1904
*R. F. Rooney (first term)	1905
*R. F. Rooney (second term—San Francisco Fire)	1906

NAME	YEAR
George H. Evans 78, The Uplands	1907
*Wesley W. Beckett	1908
*James H. Parkinson	1909
John C. King 990 Atchison Street, Pasadena	1910
*Thomas W. Huntington	1911
O. D. Hamlin Federal Realty Building Oakland	1912
*F. C. E. Mattison	1913
*H. M. Sherman (first term)	1914
*H. M. Sherman (second term—A. M. A. Meeting)	1915
George H. Kress 450 Sutter Building, San Francisco	1916
*J. H. Barbat	1917
*C. Van Zwalenburg	1918
*H. A. L. Ryfkogel	1919
*John C. Yates	1920
John H. Graves 977 Valencia Street, San Francisco	1921
*H. G. Brainerd	1922
*Thomas C. Edwards	1923
*Granville MacGowan	1924
Edward N. Ewer 251 Moss Avenue, Oakland	1925
*William T. McArthur	1926
*Percy T. Phillips	1927
William H. Kiger 1930 Wilshire Boulevard, Los Angeles	1928
Morton R. Gibbons 350 Post Street, San Francisco	1929
Lyell C. Kinney 1831 Fourth Street, San Diego	1930
Junius B. Harris 1127 Eleventh Street, Sacramento	1931
*Joseph M. King	1932
George G. Reinle 532 Fifteenth Street, Oakland	1933
Clarence G. Toland 1930 Wilshire Boulevard, Los Angeles	1934
Robert A. Peers Colfax, California	1935
Edward M. Pallette 1930 Wilshire Boulevard, Los Angeles	1936
Howard Morrow 384 Post Street, San Francisco	1937
William W. Roblee 202 Mission Inn Rotunda, Riverside	1938
Charles A. Dukes (President-elect) 426 Seventeenth Street, Oakland	1939

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* Deceased

SUPPLEMENT TO

CALIFORNIA AND WESTERN MEDICINE

Official Journal of the California Medical Association
FOUR FIFTY SUTTER, ROOM 2004, SAN FRANCISCO

VOLUME 50
NUMBER 4. (Supplement)

APRIL, 1939

50 CENTS A COPY
$5.00 A YEAR

THE N. Y. ACADEMY
OF MEDICINE
APR 21 1939
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I

Annual Session Program

Del Monte, California, May 1–4, 1939

Sixty-Eighth Annual Meeting

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II

Pre-Convention Bulletin

Reports of Officers and Committees

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Owned and Published Monthly by the California Medical Association Copyright, 1939, by the California Medical Association
"Entered as second-class matter at the post office at San Francisco, under the Act of March 3, 1879." Acceptance for mailing at special rate of postage provided for in Section 1103, Act of October 3, 1917, authorized August 10, 1918.

SALUTATION
FROM PRESIDENT ROBLEE

William W. Roblee, M.D.
President, California Medical Association
1939

To Members of the California Medical Association—

Greetings:

It is my happy privilege to extend to you a cordial invitation to attend another annual meeting of your California Medical Association, which will be held May 1 to 4.

This year we return to Del Monte, which choice we know from past experience will be a happy one. The hospitality extended by the hotel heretofore has been most cordial; the opportunities for out-of-door sports during the recreation periods are ample, and the provision made for the section meetings is satisfactory. Old friendships will be renewed, new ones acquired, and the social functions are always happy occasions.

Medicine is not static, both its science and art being constantly improved. The doctor of medicine and surgery who fails to take cognizance of new developments soon fails to render the type of service to which his patients are entitled. The papers and discussions arranged by the committee in charge are designed to bring to us, in an authentic and thorough manner, the latest developments of medical science. I urge your attendance at as many sessions as possible.

Consideration will also be given, at the first general session and at the meetings of the House of Delegates, to the present status of our medical economic problems.

There never has been a time in the history of the Association when loyalty to our national, state and county organizations was more necessary. I ask your continued interest and support, in order that those to whom you have intrusted leadership may feel that they are backed by a united profession. A good attendance at the Del Monte meeting will give them that assurance.

Cordially,

W. W. Roblee,
President.

GUEST SPEAKERS AT THE SIXTY-EIGHTH ANNUAL SESSION CALIFORNIA MEDICAL ASSOCIATION

Speakers at General Meetings

URSUS VICTOR PORTMANN, M.D.
Cleveland Clinic, Cleveland, Ohio

CHESTER SCOTT KEEFER, M.D.
Associate Professor of Medicine
Harvard University Medical School
Boston, Massachusetts

STUART WILLIAM HARRINGTON, M.D.
Professor of Surgery,
University of Minnesota Graduate School,
Rochester, Minnesota

CHARLES A. DUKES
President-elect

SECTION OFFICERS

HOWARD F. WEST
Chairman, General Medicine

LOREN R. CHANDLER
Chairman, General Surgery

GEORGE W. COON
Chairman, Obstetrics and Gynecology

WILLIAM H. BARROW
Secretary, General Medicine

RAY B. McCARTY
Secretary, General Surgery

WILLIAM BENBOW THOMPSON
Secretary, Obstetrics and Gynecology

SECTION OFFICERS

CLIFFORD B. WALKER
Chairman, Eye, Ear, Nose and Throat

JOHN G. DUNLOP
Chairman, Anesthesiology

NORMAN N. EPSTEIN
Chairman, Dermatology and Syphilology

DEWEY R. POWELL
Secretary, Eye, Ear, Nose and Throat

ADENA C. DUTTON
Secretary, Anesthesiology

ARNE E. INGELS
Secretary, Dermatology and Syphilology

HARVEY G. McNEIL
Chairman, Industrial Medicine and Surgery

ALVIN G. FOORD
Chairman, Pathology and Bacteriology

JOHN B. DOYLE
Chairman, Neuropsychiatry

SECTION OFFICERS

JOHN S. STEPHENS
Secretary, Industrial Medicine and Surgery

ROY W. HAMMACK
Secretary, Pathology and Bacteriology

GEORGE S. JOHNSON
Secretary, Neuropsychiatry

HAROLD K. FABER
Chairman, Pediatrics

CARL F. RUSCHE
Chairman, Urology

KARL M. BONOFF
Chairman, Radiology

HARTZELL H. RAY
Secretary, Pediatrics

JOHN A. DOUGHERTY
Secretary, Urology

CARL D. BENNINGHOVEN
Secretary, Radiology

Part I

PROGRAM

THE SIXTY-EIGHTH ANNUAL SESSION *of the* CALIFORNIA MEDICAL ASSOCIATION

TO BE HELD AT

HOTEL DEL MONTE, DEL MONTE

MAY 1–4, 1939

OFFICERS AND COMMITTEES, 1939

GENERAL OFFICERS

William W. Roblee, Riverside, President
Charles A. Dukes, Oakland, President-Elect
Howard Morrow, San Francisco, Past President
Lowell S. Goin, Los Angeles, Speaker of House of Delegates
John H. Graves, San Francisco, Vice-Speaker of House of Delegates
Karl L. Schaupp, San Francisco, Chairman of Council
Junius B. Harris, Sacramento, Vice-Chairman of Council
T. Henshaw Kelly, San Francisco, Chairman, Executive Committee
George H. Kress, San Francisco, Secretary-Treasurer–Editor
George G. Reinle, Oakland, Chairman, Committee on Public Relations
Hartley F. Peart, San Francisco, General Counsel
Hubert T. Morrow, Los Angeles, Associate General Counsel

COUNCILORS

First District

Calvert L. Emmons, Ontario (1941)
Imperial, Orange, Riverside, San Bernardino and San Diego Counties

Second District

Carl R. Howson, Los Angeles (1939)
Los Angeles County

Third District

Louis A. Packard, Bakersfield (1940)
Kern, San Luis Obispo, Santa Barbara, and Ventura Counties

Fourth District

Axcel E. Anderson, Fresno (1941)
Calaveras, Fresno, Inyo, Kings, Madera, Mariposa, Merced, Mono, San Joaquin, Stanislaus, Tulare, and Tuolumne Counties

Fifth District

Alfred L. Phillips, Santa Cruz (1939)
Monterey, San Benito, San Mateo, Santa Clara and Santa Cruz Counties

Sixth District

Karl L. Schaupp, San Francisco (1940)
San Francisco County

Seventh District

Oliver D. Hamlin, Oakland (1941)
Alameda and Contra Costa Counties

Eighth District

Frederick N. Scatena, Sacramento (1939)
Alpine, Amador, Butte, Colusa, Eldorado, Glenn, Lassen, Modoc, Nevada, Placer, Plumas, Sacramento, Shasta, Sierra, Sutter, Tehama, Yolo, and Yuba Counties

Ninth District

Henry S. Rogers, Petaluma (1940)
Del Norte, Humboldt, Lake, Marin, Mendocino, Napa, Siskiyou, Solano, Sonoma, and Trinity Counties

Councilors-at-Large

Junius B. Harris, Sacramento (1940)
Harry H. Wilson, Los Angeles (1941)
C. O. Tanner, San Diego (1939)
William H. Kiger, Los Angeles (1940)
Philip K. Gilman, San Francisco (1941)
T. Henshaw Kelly, San Francisco (1939)

DELEGATES AND ALTERNATES TO A. M. A.

Delegates	*Sessions*	*Alternates*
Elbridge Best San Francisco	(1939)	Robert S. Stone San Francisco
Lyell C. Kinney San Diego	(1939)	Bon. O. Adams Riverside
J. P. Nuttall Los Angeles	(1939)	F. M. Pottenger Los Angeles
George G. Reinle Oakland	(1939–1940)	Frank R. Makinson Oakland
Edward M. Pallette Los Angeles	(1939–1940)	William H. Kiger Los Angeles
Robert A. Peers Colfax	(1939–1940)	F. F. Gundrum Sacramento
William R. Molony, Sr., Los Angeles	(1939–1940)	John C. Ruddock Los Angeles

STANDING COMMITTEES

Executive Committee

The President, the President-elect, the Speaker of the House of Delegates, the Chairman of the Council, the Chairman of the Auditing Committee, the Chairman of the Committee on Public Relations, the Past President, the Secretary-Treasurer, and the Editor. (T. Henshaw Kelly, chairman; George H. Kress, secretary.)

Auditing Committee

O. D. Hamlin, Oakland	1939
T. Henshaw Kelly (Chairman), San Francisco	1939
Philip K. Gilman, San Francisco	1939

Members of the Auditing Committee are appointed each year by the Chairman of the Council.

Committee on Associated Societies and Technical Groups

William H. Geistweit, San Diego	1939
John V. Barrow (Chairman), Los Angeles	1940
Edwin L. Bruck, San Francisco	1941

Committee on Health and Public Instruction

W. R. P. Clark, San Francisco	1939
Benjamin W. Black, Oakland	1940
Fred B. Clarke (Chairman), Long Beach	1941

Committee on History and Obituaries

J. Marion Read, San Francisco	1939
A. Elmer Belt, Los Angeles	1940
Frank R. Makinson (Chairman), Oakland	1941

Secretary ex officio
Editor ex officio

Committee on Hospitals, Dispensaries, and Clinics

W. Earl Mitchell (Chairman), Oakland	1939
Karl L. Schaupp, San Francisco	1940
George Dawson, Napa	1941

Committee on Industrial Practice

Philip Stephens (Chairman), Los Angeles	1939
Harry E. Zaiser, Orange	1940
Morton R. Gibbons, San Francisco	1941

Committee on Medical Defense

Fred R. De Lappe, Modesto	1939
John P. Nuttall, Santa Monica	1940
George G. Reinle (Chairman), Oakland	1941

Committee on Medical Economics

William R. Molony, Sr., Los Angeles	1939
Edward M. Pallette, Los Angeles	1940
John H. Graves (Chairman), San Francisco	1941

Committee on Medical Education and Medical Institutions

Loren R. Chandler (Chairman), San Francisco	1939
John B. Doyle, Los Angeles	1940
B. O. Raulston, Los Angeles	1941

Committee on Membership and Organization

Dewey R. Powell, Stockton	1939
G. Dan Delprat, San Francisco	1940
George D. Maner (Chairman), Los Angeles	1941

Committee on Postgraduate Activities

F. F. Gundrum, Sacramento	1939
John C. Ruddock (Chairman), Los Angeles	1940
F. E. Clough, San Bernardino	1941
Secretary ex officio	

Committee on Publications

Oscar Reiss, Los Angeles	1939
Ralph Eusden (Chairman), Los Angeles	1940
Ruggles A. Cushman, Talmage	1941
Secretary ex officio	
Editor ex officio	

Committee on Public Policy and Legislation

T. Henshaw Kelly, San Francisco	1939
E. T. Remmen, Glendale	1940
Junius B. Harris (Chairman), Sacramento	1941
President ex officio	
President-elect ex officio	

Committee on Scientific Work

F. M. Pottenger, Monrovia	1939
Lemuel P. Adams, Oakland	1940
J. Homer Woolsey, Woodland	1941
William H. Barrow, Secretary of Section on General Medicine, ex officio	
Ray B. McCarty, Secretary of Section on General Surgery, ex officio	
George H. Kress (Chairman), ex officio	

Committee on Public Relations

The Committee on Public Relations consists of the chairmen of the following standing committees and of certain general officers of the Association, all serving ex officio. The chairman of the committee is George G. Reinle, the secretary is George H. Kress. The director of the Department of Public Relations is George H. Kress. The chairman of the Committee on Public Relations is ex officio a member of the Council.

Fred B. Clarke, Chairman, Committee on Health and Public Instruction.

W. Earl Mitchell, Chairman, Committee on Hospitals, Dispensaries, Clinics.

Philip Stephens, Chairman, Committee on Industrial Practice.

George G. Reinle, Chairman, Committee on Medical Defense.

George D. Maner, Chairman, Committee on Membership and Organization.

John H. Graves, Chairman, Committee on Medical Economics.

Junius B. Harris, Chairman, Committee on Public Policy and Legislation.

Alson R. Kilgore, Chairman, Cancer Commission.

John C. Ruddock, Chairman, Committee on Postgraduate Activities.

William W. Roblee, President of California Medical Association.

Charles A. Dukes, President-elect.

George H. Kress, Secretary-Treasurer.

Communications for the Public Relations Department should be addressed to the Director, George H. Kress, M.D., Room 2004, 450 Sutter Street, San Francisco.

Cancer Commission

Alson R. Kilgore (Chairman), San Francisco	1939
Henry J. Ullmann, Santa Barbara	1939
Clarence G. Toland, Los Angeles	1939
Charles A. Dukes, Oakland	1940
Lyell C. Kinney (Vice-Chairman), San Diego	1940
Otto H. Pflueger (Secretary), San Francisco	1940
Orville Meland (Secretary for Southern Section), Los Angeles	1941
A. Herman Zeiler, Los Angeles	1941
Gertrude Moore, Oakland	1941

Communications for the Cancer Commission should be addressed to the Secretary, Otto H. Pflueger, M.D., Room 2004, 450 Sutter Street, San Francisco.

SPECIAL COMMITTEES

Committee on Medical Research

Philip Gilman (Chairman)	San Francisco
Charles A. Dukes	Oakland
Loren R. Chandler	San Francisco

Committee on Arrangements

Mast Wolfson (Chairman)	Monterey
Alfred L. Phillips	Santa Cruz
W. M. Gratiot	Monterey
Curtis B. Gorham	Monterey
H. R. Lusignan	Monterey
Association Secretary ex officio	

Committee on Maternal Welfare

T. Henshaw Kelly	San Francisco
Lyle G. McNeile	Los Angeles
Ralph J. Thompson	Los Angeles
T. Floyd Bell	Oakland
Hans F. Schluter	Sacramento

Committee on Golden Gate International Exposition

T. Henshaw Kelly (Chairman)	San Francisco
Edward M. Pallette	Los Angeles
Karl F. Meyer	San Francisco
Charles A. Dukes	Oakland
Hartley F. Peart	San Francisco

Committee on Hospitals

Louis A. Packard (Chairman)	Bakersfield
Axcel E. Anderson	Fresno
Calvert L. Emmons	Ontario

Committee on Syphilis

Howard Morrow (Chairman)	San Francisco
Charles W. Barnett	San Francisco
William H. Goeckerman	Los Angeles

Committee on a Qualifying Certificate (Basic Science) Law

George H. Kress (General Chairman)	San Francisco
Morton R. Gibbons (Chairman for Bay Region)	San Francisco
Edward M. Pallette, (Chairman for Southern California)	Los Angeles
Junius B. Harris (Chairman for Remainder of State)	Sacramento

MEMBERS OF HOUSE OF DELEGATES—36th ANNUAL SESSION

TOTAL DELEGATES (162)

DELEGATES EX OFFICIO (22)

William W. Roblee, Riverside	President
Charles A. Dukes, Oakland	President-Elect
Howard Morrow, San Francisco	Past President
Lowell S. Goin, Los Angeles	Speaker of House of Delegates
John H. Graves, San Francisco	Vice-Speaker of House of Delegates
George H. Kress, San Francisco	Secretary-Treasurer-Editor
C. L. Emmons, Riverside (1941)	Councilor 1st District
Carl R. Howson, Los Angeles (1939)	Councilor 2nd District
Louis A. Packard, Bakersfield (1940)	Councilor 3rd District
Axcel E. Anderson, Fresno (1941)	Councilor 4th District
Alfred L. Phillips, Santa Cruz (1939)	Councilor 5th District
Karl L. Schaupp, San Francisco (1940)	Councilor 6th District
Oliver D. Hamlin, Oakland (1941)	Councilor 7th District
Frederick N. Scatena, Sacramento (1939)	Councilor 8th District
Henry S. Rogers, Petaluma (1941)	Councilor 9th District
Harry H. Wilson, Los Angeles (1941)	Councilor-at-Large
C. O. Tanner, San Diego (1939)	Councilor-at-Large
William H. Kiger, Los Angeles (1940)	Councilor-at-Large
P. K. Gilman, San Francisco (1941)	Councilor-at-Large
T. Henshaw Kelly, San Francisco (1939)	Councilor-at-Large
Junius B. Harris, Sacramento (1940)	Councilor-at-Large
George G. Reinle, Oakland	Chairman, Committee on Public Relations

ELECTED DELEGATES (140)

Alameda County (11)

Delegates	*Alternates*
Dorothy Allen	H. H. Appledorn
Leonard Barnard	C. J. Burnham, Jr.
Frank H. Bowles	J. V. Campbell
W. W. Crane	Jefferson Larkey
Clarence A. DePuy	Lester B. Lawrence
John Dougherty	Norman Leet
Sumner Everingham	George Nesche
F. C. Kracaw	F. G. Novy, Jr.
Robert S. Peers	J. R. Sharpsteen
Leland H. Taylor	J. W. Sherrick
H. J. Templeton	Bruce M. Stephens

Butte County (1)

Dan H. Moulton	Newton T. Enloe

Contra Costa County (2)

S. N. Weil	W. L. Taylor
Koho Daily	Clifford E. Dieterich

Fresno County (3)

Neil J. Dau	G. Manson
H. A. Randel	L. Glynne Price
G. W. Walker	E. J. Schmidt

Humboldt County (1)

Wilson Stegeman	Lane Falk

Imperial County (1)

L. C. House	Philip Hodgkin

Kern County (2)

C. S. Compton	H. W. Jones
F. J. Gundry	John J. McCarthy

Kings County (1)

Not Received	Not Received

Lassen-Plumas-Modoc County (1)

Not Received	Not Received

Los Angeles County (48)

Delegates	*Alternates*
L. A. Alesen	C. Max Anderson
E. Vincent Askey	Edwin S. Bennett
Samuel Ayres, Jr.	A. A. Blatherwick
Wilbur Bailey	H. T. S. Bonesteel
Harold Dewey Barnard	H. B. Breitman
Karl M. Bonoff	Frank J. Breslin
E. M. Burns	William H. Brownfield
T. D. Caruso	John W. Budd
Fred B. Clarke	O. W. Butler
Lyle G. Craig	Donald Cass
Jay J. Crane	R. Manning Clarke
Walter R. Crane	A. B. Cooke
John W. Crossan	William E. Costolow
William H. Daniel	Kenneth S. Davis
Edward B. Dewey	Robert H. Fagan
Wallace Dodge	Roy E. Fallas
Ralph B. Eusden	Dozier H. Gibbs
Donald J. Frick	William M. Gibbs
Henry C. Gernand	John D. Gillis
Orrie Ghrist	Scott D. Gleeten
Roy W. Hammack	William M. Happ
V. J. Keating	Leland Hawkins
E. Eric Larson	Herold P. Hare
George D. Maner	Charles M. Hayes
Orville N. Meland	Edward W. Hayes
William R. Molony, Sr.	Morrill L. Ilsley
E. Earl Moody	John C. Jones
Carl L. Mulfinger	Paul C. Lawyer
Thomas Chalmers Myers	Louis E. Martin
John P. Nuttall	Robert J. Moes
Frank W. Otto	Herbert S. Mooney
Edward M. Pallette	Clarence H. Nelson
H. A. Putnam	Edward C. Pallette
Robert E. Ramsay	George H. Patterson
Burrell O. Raulston	Paul A. Quaintance
Edward N. Reed	Marcus Rabwin
Edmund T. Remmen	Oscar Reiss
John C. Ruddock	Paul B. Roen
Harlan Shoemaker	V. DeMott Sedgwick
Henry Snure	Reginald H. Smart
Philip Stephens	Kenneth E. Smiley
Joseph B. Stevens	John Stephens
R. G. Taylor	Roy A. Terry
Roy E. Thomas	Packard Thurber
Donald G. Tollefson	H. D. Van Fleet
George D. Wells	Harry J. Wiley
Walter Wessels	Robert W. Wilcox
Howard F. West	Charles S. Young

Marin County (1)

Carl W. Clark	W. Scott Polland

Mendocino-Lake County (1)

Ruggles A. Cushman	George T. Barcklow

Merced County (1)

E. A. Jackson	Fred O. Lien

Monterey County (2)

L. P. Davlin	J. B. McCarthy
Mast Wolfsohn	J. A. Merrill

Napa County (1)

George I. Dawson	Dwight H. Murray

Orange County (3)

Dexter R. Ball	F. Harold Gobar
Harry G. Huffman	Merrill W. Hollingsworth
G. Wendell Olson	Milo K. Tedstrom

Placer County (1)

Lucas W. Empey	Mildred E. Thoren

Riverside County (2)

Bon O. Adams	W. P. Corr
A. L. Bramkamp	H. L. Ratliff

Sacramento County (3)

H. M. Kanner	Paul Guttman
Frank MacDonald	Wayne Pollock
R. M. Wallerius	Ralph Teall

San Benito County (1)

Roswell L. Hull	Robert S. Geen

San Bernardino County (4)

Walter Cherry	Robert C. Nichols
Albert D. Neubert	Arthur L. Weber
Xenophon Olsen	Thomas I. Zirkle
Delbert B. Williams	Harold G. Gentry

Delegates	*Alternates*
San Diego County (6)	
A. J. Cooper	W. W. Belford
H. G. Holder	D. E. Corbin
S. J. McClendon	W. L. Garth
W. H. Newman	C. W. Lane
B. R. Simpson	J. G. Omelvena
F. E. Toomey	P. E. Wedgewood
San Francisco County (19)	
Stanley H. Mentzer	Leo H. Garland
Alson R. Kilgore	Gerald B. O'Connor
J. C. Geiger	Howard A. Brown
Frederic C. Bost	Zera E. Bolin
Robert R. Newell	Robert S. Stone
Elbridge J. Best	David A. Wood
G. Dan Delprat	Rodney A. Yoell
Edwin L. Bruck	Mary Jones Mentzer
Harold A. Hill	James W. Morgan
John J. Sampson	Ernst Gehrels
Dohrmann K. Pischel	Nelson J. Howard
H. Glenn Bell	LeRoy Brooks
George Warren Pierce	Leon O. Parker
Irving S. Ingber	August H. Rosburg
Howard W. Fleming	Thomas E. Gibson
Jesse L. Carr	Roberto Escamilla
William C. Voorsanger	Russell Fletcher
John W. Cline	Roland P. Seitz
Warren D. Horner	Richard B. Jones
San Joaquin County (3)	
Frank J. Doughty	C. A. Broaddus
Dewey R. Powell	R. T. McGurk
G. H. Sanderson	C. V. Thompson
San Luis Obispo County (1)	
F. R. Mugler	Charles R. Kennedy
San Mateo County (2)	
J. Garwood Bridgman	H. Wade Macomber
Hartzell H. Ray	N. D. Morrison, Sr.
Santa Barbara County (3)	
Harry E. Henderson	Dan M. Clark
Edward L. Markthaler	Hugh F. Freidell
Caleb S. Stone, Jr.	Percival Allen Gray

Delegates	*Alternates*
Santa Clara County (4)	
C. Kelly Canelo	Dudley Fagerstrom
Russel V. Lee	Horace Jones
R. Stanley Kneeshaw	Leslie B. Magoon
John H. Shephard	Merlin T.-R. Maynard
Santa Cruz County (1)	
J. T. Harrington	S. W. Dowling
Shasta County (1)	
B. L. Trelstad	O. J. Hansen
Siskiyou County (1)	
C. C. Dickenson	V. W. Hart
Solano County (1)	
John W. Green	R. S. Leachman
Sonoma County (2)	
D. C. Oakleaf	L. W. Hines
A. A. Thurlow	C. Marsh
Stanislaus County (1)	
R. S. Hiatt	Hans Hartman
Tehama County (1)	
F. J. Bailey	Donald Thompson
Tulare County (1)	
E. R. Zumwalt	Newton Miller
Ventura County (1)	
Arlo A. Morrison	Grundy C. Coffey
Yolo-Colusa-Glenn County (1)	
John Homer Woolsey	T. H. Brown
Yuba-Sutter County (1)	
Neal M. Loomis	Stanley R. Parkinson

* * *

REGISTRATION INFORMATION

Registration and Information. The registration and information desk is located in the west lobby, adjacent to the entrance of the dining room, Del Monte Hotel. All persons attending the convention, whether members or not, are requested to register immediately on arrival. Beginning on Monday, May 1, registration secretaries will be on duty daily from 9 a. m. until 5 p. m.

Programs and Pre-Convention Bulletin. The registration clerks will give to every member a copy of the program. The Pre-Convention Bulletin will appear as a supplement to the April issue of CALIFORNIA AND WESTERN MEDICINE. Delegates and alternates are especially requested to read the reports of officers and committees.

Guests and Visitors. All guests and visitors are requested to register. All general meetings and scientific meetings are open to visitors and guests.

Badges. Four kinds of badges will be issued by the registration bureau:

1. *Members.* Only active, associate, retired, or honorary members of the California Medical Association will be issued the usual membership badge.

2. *Guests.* A guest badge will be issued to all fraternal delegates and visiting physicians who are attending this year's session.

3. *Delegates and Alternates.* The usual official badge for each delegate and alternate is provided for this purpose, and will be issued only to one authorized to wear it.

4. *Officers.* An official badge is provided for all officers and members of the Council.

Announcements. Please register on arrival and secure program and special announcements. Registration Bureau, Del Monte Hotel.

The program as given in this Pre-Convention Bulletin indicates the tentative arrangements. These are subject to change. The final or reprint program, a copy of which will be given to each member as he registers, will contain additional and detailed information on matters not appearing in the Pre-Convention Bulletin.

Delegates will please file *credentials* with the House of Delegates committee at 7:30 to 8 p. m., at each meeting of the House.

Consult bulletin board daily for schedule of *Scientific Exhibit Demonstrations.*

Consult diagram for *meeting places of Scientific Sections.* Diagram will be printed in the final program.

President's Dinner Tickets. Tickets for the dinner to the President must be gotten at the hotel desk. Members who are registered as guests at the Hotel Del Monte must also secure special tickets at the hotel desk.

Golf. Please register for tournaments at the California Medical Association registration desk. Also consult bulletin boards.

Riding Horses. Please register at the California Medical Association registration desk for services of groom.

Swimming Pool. For information, apply at hotel desk.

Woman's Auxiliary members register at Hotel Del Monte, main lobby, immediately opposite hotel's registration desk.

Consult program for *entertainment events.*

Visit the *commercial exhibits.*

Suggestions and Constructive Criticism. The officers and committees have tried to do everything possible to make the session a success. Suggestions and constructive criticism calculated to make future sessions more useful will be welcomed by any of the officers. Complaints of whatever character should be promptly made at the registration desk, where they will receive attention.

PROGRAM: BY DAYS

Sunday, April 30

9:00 a. m. to 4:30 p. m.—Pathologic Conference (under auspices of the Cancer Commission).

10:00 a. m. to 4:00 p. m.—Radiologic Conference (under auspices of the Cancer Commission).

12:00 noon to 5:00 p. m.—Scientific and commercial exhibits.

12:00 noon—North and South Golf Tournament.

2:00 p. m.—Conference of County Society Secretaries.

7:30 p. m.—Council meeting.

Monday, May 1

10:00 a. m.—Opening General Meeting.

1:30 p. m.—Section meetings.

8:00 p. m.—House of Delegates.*

Tuesday, May 2

7:45 a. m.—Past Presidents' breakfast.

8:30 a. m.—Section meetings.

11:15 a. m.—General Meeting (Clinical-Pathological Conference).

1:00–6:00 p. m.—Recreation. (Golf, skeet shoot, seventeen-mile drive). Tuesday afternoon is set aside for entertainment features. No section meetings on Tuesday afternoon. (See items under Registration Information, and under "X—Del Monte.")

7:30 p. m.—President's dinner, reception, and dance.

Wednesday, May 3

8:30 a. m.—Section meetings.

11:15 a. m.—General Meeting (Social Security, legislation, and economics).

1:30 p. m.—Section meetings.

4:15 p. m.—Meeting of "Medical Society of the State of California."

8:00 p. m.—House of Delegates.*

Thursday, May 4

8:30 a. m.—Section meetings.

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Note.—Council meets daily during the annual session.

Watch bulletin board for hours during which film and other demonstrations will be given in the Scientific Exhibits Section.

Utilize every opportunity to visit the commercial and technical exhibits.

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* In order to permit the House of Delegates to be called to order at 8 p. m., all delegates are requested to register with the Credentials Committee between 7:30 p. m. and 8 p. m. at each meeting.

* * *

I—GENERAL MEETINGS

All General Meetings will be held in the Auditorium, on the ground floor, Hotel Del Monte

First General Meeting

Monday, May 1, 10 a.m.

Address of Welcome—Walter P. Farr, M.D., President of the Monterey County Medical Society.

Address of President—William W. Roblee, M.D., Riverside, President, California Medical Association.

California Physicians' Service—T. Henshaw Kelly, M.D., San Francisco, Chairman of the Executive Committee, California Physicians' Service.

Medicine and Surgery Under the California Physicians' Service—Morton R. Gibbons, Sr., M.D., San Francisco, Medical Director of the California Physicians' Service.

Diaphragmatic Hernia—Stuart W. Harrington, M. D., Rochester, Minnesota, Professor of Surgery, University of Minnesota Graduate School, Rochester, Minnesota.

Second General Meeting

Tuesday, May 2, 11:15 a.m.

President William W. Roblee, Presiding

William H. Barrow, Director

Clinical-Pathological Conference—Conducted by Chester S. Keefer, M.D., Associate Professor of Medicine, Harvard Medical School, Boston; William Dock, M. D., Professor of Pathology, Stanford Medical School, San Francisco; and Jesse Carr, M.D., University of California Hospital, San Francisco.

Note.—Protocols of the cases under discussion, with complete clinical histories and laboratory findings, will be distributed. These case histories will be discussed by the guest speaker and differential diagnoses presented, following which the pathological findings will be presented and discussed.

The three cases may be summarized briefly as follows:

1. Febrile illness of two years' duration; appendectomy and nephropexy without relief of abdominal pain.
2. Severe hypertension noted after pneumonia in a man whose pressure was normal a few months before. Postoperative complications following splanchnic nerve resection.
3. Twenty-five years of "peptic ulcer" history followed by appearance of abdominal masses, cough, and hemoptysis.

Third General Meeting †

Wednesday, May 3, 11:15 a.m.

Pending State Legislation—Junius B. Harris, M.D., Sacramento, Chairman of the Committee on Public Policy and Legislation.

On Periodic Payment Medical Service Plans—Lowell S. Goin, M.D., Los Angeles, Vice-President of the Board of Trustees, California Physicians' Service.

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† The third general session will immediately follow the paper given in the Section on Medicine, on "The Practical Interpretation of Laboratory Tests in the Diagnosis of Infectious Disease," by Chester S. Keefer, M. D., Associate Professor of Medicine, Harvard Medical School, Boston.

II—SECTION MEETINGS

SCIENTIFIC SECTION PROGRAMS

(Numbers in parenthesis after each section indicate sequence reference numbers of papers read in each section.)

I.—General Medicine (1-22) 11
II.—General Surgery (23-42) 14
III.—Obstetrics and Gynecology (43-53) 16
IV.—Eye, Ear, Nose and Throat (54-66) 17
V.—Anesthesiology (67-75) 19
VI.—Dermatology and Syphilology (76-87) 19
VII.—Industrial Medicine and Surgery (88-95) 21
VIII.—Neuropsychiatry (96-99) 22
IX.—Pathology and Bacteriology (100-109) 23
X.—Pediatrics (110-113) 24
XI.—Radiology (114-123) 25
XII.—Urology (124-133) 27

Rules Regarding Papers and Discussions at the State Meetings

Upon the recommendation of the Executive Committee the following rules regarding papers have been adopted by the Council:

1. The maximum time that may be consumed by any paper is fifteen minutes, provided that not to exceed ten minutes' latitude may be allowed invited guests at the discretion of the presiding chairman.

2. Motions from the floor to extend the time of an author may be entertained by the presiding officer.

3. The maximum time permitted any individual to discuss a paper is four minutes. This also applies to the author in closing his discussion. No speaker may discuss more than once any one subject.

4. A copy of each and every paper presented at the state meeting must be in the hands of the chairman or secretary of the section or in the hands of the general secretary before the paper is presented.

5. All papers read at the annual meeting may be published in full in CALIFORNIA AND WESTERN MEDICINE as soon after the meeting as space will permit; or at the option of the author, an abstract of the paper of about one column in length shall be published as soon as possible after the meeting, with reprints in full of the entire paper (the cost of setting up type for the reprint to be borne by the Association, and all other costs to be borne by the author).

6. Articles are accepted for publication on condition that they are contributed solely to CALIFORNIA AND WESTERN MEDICINE. Authors desiring to publish their papers elsewhere than in the JOURNAL may have their manuscripts returned to them upon written request to the editor.

7. No paper will be accepted by the General Program Committee nor by Section program committees unless accompanied by a synopsis of not to exceed fifty words.

8. Papers shall not be "read by title."

9. No member may present more than one paper at any one state meeting, provided that a member may be a collaborator on more than one paper, if these papers are presented by different authors.

10. Failure on the part of an author to present a paper precludes acceptance of future papers from such author for a period of two years, unless the author explains to the satisfaction of the Executive Committee his inability to fulfill his obligation.

Section Papers: How Numbered

For convenience in reference, papers are numbered in serial sequence for the entire session, instead of a separate sequence for each section.

Business Meetings of Sections

Time of business meetings and elections of officers of sections will be scheduled on section blackboards by section secretaries, and through preliminary announcements by section chairmen.

Unless otherwise announced, the business meetings of each section and the election of officers will be held immediately after the reading of the second paper on the second day's section program.

I

GENERAL MEDICINE SECTION

HOWARD F. WEST, M.D., *Chairman*
1930 Wilshire Boulevard, Los Angeles

WILLIAM H. BARROW, M.D., *Secretary*
1400 Medico-Dental Building, San Diego

First Meeting

Monday, May 1, 1:30 p. m.

SYMPOSIUM ON SULFANILAMID

This will be a joint meeting with the General Surgery Section.

Paper No. 1:

Pharmacology of Sulfanilamid and Related Compounds—Windsor C. Cutting, M.D., Department of Pharmacology, Stanford Medical School, and William L. Cover, M.D., San Bernardino.

Sulfanilamid, neoprontosil, and sulfapyridin will be compared briefly chemically and in their general effects on bacteria. The controversy concerning the mode of action, and the differences in absorption, distribution, excretion, toxicity, and therapeutic use will be discussed in some detail.

Paper No. 2:

Sulfanilamid and Sulfapyridin in the Treatment of Various Infections—Chester S. Keefer, M. D., Associate Professor of Medicine, Harvard Medical School, Boston, Massachusetts. (By invitation.)

The results of the use of sulfanilamid in the treatment of hemolytic streptococcal, gonococcal, meningococcal, and urinary-tract infections will be summarized, and its mode of action and toxic effects will be discussed. A new derivative of sulfanilamid, sulfapyridin, has been used for the treatment of pneumococcus pneumonia. The present status of this drug will be reviewed. Its indications, mode of action, and side effects will be stressed.

Paper No. 3:

Urological Uses of Sulfanilamid—Bernard Silver, M.D., 1712 North Highland, Hollywood.

In the three years since the introduction of sulfanilamid in urologic practice its efficacy in gonorrhea has been established in many large series of cases, but despite this, its effect on the total incidence of gonorrhea has been apparently small.

In nonspecific infections of the upper urinary tract, sulfanilamid is more effective than all previous antiseptics, but it is an adjunct to mechanical urologic procedures, because without removal of obstructive factors the infection has either failed to respond or the infection has promptly recurred after its discontinuance.

Paper No. 4:

Sulfanilamid in Surgical Practice—Arthur Haim, M.D., 450 Sutter Street, San Francisco.

Discussion of the use of sulfanilamid compounds in conditions met with in surgical practice, with special emphasis on indications and contra-indications. Lantern slides will illustrate the immunobiologic management of a series of severe hemolytic streptococcus infections in which chemotherapy was used.

Discussion by William Mitchell, M.D., Los Angeles; Edgar Wayburn, M.D., San Francisco; Clayton Lyon, M.D., San Francisco; Shuler F. Fagan, M.D., Los Angeles.

Section Aides: Clarence H. Nelson, M.D., Los Angeles; Raymond D. Kay, M.D., Los Angeles; Mast Wolfsohn, M.D. Monterey; Garnett Cheney, M.D., San Francisco.

Second Meeting

Tuesday, May 2, 8:30 a. m.

SYMPOSIUM ON ALCOHOLISM

This will be a joint meeting with the Neuropsychiatry Section.

Paper No. 5:

The Importance of Individual Tolerance to Alcohol in the Evaluation of Chemical Tests of Drunkenness—Henry W. Newham, M.D., Stanford University School of Medicine, San Francisco.

The metabolism of alcohol proceeds at a constant rate, and is peculiarly resistant to change. It is thus possible to estimate, from one blood alcohol determination, the blood alcohol concentration at some previous time. The determination of alcohol in body fluids or in breath is simple and accurate. The weak point in the chemical diagnosis of drunkenness is due, however, to the fact that different individuals do not show the same degree of intoxication with the same blood alcohol concentration, due to inherent and acquired tolerance to alcohol. This tolerance has been shown to be a true tissue tolerance, and is not due to decreased absorption or increased elimination of alcohol.

Paper No. 6:

Psychiatric Treatment of Alcoholism—J. L. Henderson, M.D., Compton Sanitarium, Compton.

Alcoholism is widespread, has serious economic, social and medical aspects, and its treatment is probably second in human importance only to that of schizophrenia. Recently, literature points toward the family background of the alcoholic as being of major etiologic significance. This, it appears, has a profound influence upon the development of the individual's personality, and it is in this setting that alcoholism develops. Thus it is that we speak of an "alcoholic personality." Certain classifications can be applied to alcoholics, and this is of help principally in the matter of prognosis. The present commitment laws, discussed and compared with commitment laws of other states. Treatment of alcoholism in the state hospitals is reviewed. Approach to the problem through intensive psychotherapy is outlined and problems involved in individual treatment discussed. This approach has certain advantages and certain limitations. Its contributions to the solution of the problem of alcoholism are evaluated.

Paper No. 7:

Subacute Alcoholic Cirrhosis of the Liver: A Clinical and Pathological Study of Eighty Cases—Ernest M. Hall, M.D., University of Southern California School of Medicine, Los Angeles; W. A. Morgan, M. D., Los Angeles County Hospital, Los Angeles.

A study of some eighty cases of cirrhosis in the early phase in which the liver is enlarged and often fatty, showing a subacute proliferative inflammation. Such livers selected on anatomic grounds were associated with chronic alcoholism in 80 per cent of the patients.

Paper No. 8:

The Use of Vitamins in the Treatment of Alcoholic Disorders—John M. Askey, M.D., 902 Wilshire Medical Building, Los Angeles.

A review of the recent developments in the recognition of the rôle of vitamin deficiencies in the etiology of alcoholic disorders; with a discussion of the present trend in therapy.

Discussion by Emil Bogen, M.D., Los Angeles; Percy Poliak, M.D., San Francisco; John M. Nagle, M.D., Agnew; P. J. Hanzlik, M.D., San Francisco; Newton Evans, M.D., Los Angeles; Charles L. Connor, M.D., San Francisco; George H. Houck, M.D., Los Angeles.

Paper No. 9*:

Clinical-Pathological Conference—Conducted by Chester S. Keefer, M.D., Associate Professor of Medicine, Harvard Medical School, Boston; William Dock, M. D., Professor of Pathology, Stanford Medical School, San Francisco; and Jesse Carr, M.D., University of California Hospital, San Francisco.

Note.—Protocols of the cases under discussion, with complete clinical histories and laboratory findings, will be distributed. These case histories will be discussed by the guest speaker and differential diagnoses presented, following which the pathological findings will be presented and discussed.

The three cases may be summarized briefly as follows:

1. Febrile illness of two years' duration; appendectomy and nephropexy without relief of abdominal pain.
2. Severe hypertension noted after pneumonia in a man whose pressure was normal a few months before. Postoperative complications following splanchnic nerve resection.
3. Twenty-five years of "peptic ulcer" history followed by appearance of abdominal masses, cough, and hemoptysis.

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Third Meeting

Wednesday, May 3, 8:30 a. m.

Paper No. 10:

The Treatment of Syphilis in the Tuberculous Patient—Walter Beckh, M.D., 490 Post Street, San Francisco.

The problems incident to the coexistence of syphilis and tuberculosis are considered, and a discussion of the correlation of the treatment of syphilis and tuberculosis is presented.

Discussion by George V. Kulchar, M.D., San Francisco; Philip Pierson, M.D., San Francisco.

Paper No. 11:

Anemia as a Cause of Angina Pectoris—Francis M. Smith, M.D., Scripps Metabolic Clinic, La Jolla.

Case reports and review of literature to show that cardiac pain indistinguishable from angina pectoris may be a symptom of anemia. Anemia, particularly pernicious anemia, may be masked by severe angina pectoris. Considerations of angina pectoris in relation to various factors, as hemoglobin levels, presence or absence of coronary arterial disease, and reactions to therapy of the underlying anemia.

Discussion by Franklin Nuzum, M.D., Santa Barbara; E. Manning Clarke, Los Angeles.

Paper No. 12:

Chairman's Address—Causes of Death in Diabetes: An Autopsy Review—Howard F. West, M.D., 1930 Wilshire Boulevard, Los Angeles.

The active literature on diabetes deals chiefly with problems relating to diabetes as a disease entity. With better measures of control the diabetic's life is being increasingly prolonged. An autopsy study has been made to illustrate primarily the clinical problems involved in the care of these patients aside from specific treatment.

Paper No. 13:

The Practical Interpretation of Laboratory Tests in the Diagnosis of Infectious Diseases—Chester S. Keefer,

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* This Clinical-Pathologic Conference will be a General Meeting, commencing at 11:15 a.m. Presiding, President William W. Roblee, M. D.; Director, William H. Barrow, M. D. See special notice under General Meetings.

M. D., Associate Professor of Medicine, Harvard Medical School, Boston, Massachusetts (By invitation.)

There is no group of diseases in which the physician relies more on laboratory examinations than in the diagnosis of infectious diseases. The various bacteriologic and serologic examinations which are in common use will be discussed and assessed in the light of present-day knowledge, and illustrative cases will be cited to stress both the value and the limitations of laboratory methods in diagnosis.

Business Recess

Business meeting and election of officers.

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Fourth Meeting

Wednesday, May 3, 1:30 p. m.

SYMPOSIUM ON POLIOMYELITIS

This is a joint session of Medicine and Pediatrics Sections.

Paper No. 14:

The Basic Nature of Poliomyelitic Infection—Harold K. Faber, M.D., Stanford University School of Medicine, San Francisco.

In this paper will be discussed the virus of poliomyelitis, its tissue affinities, its mode of entrance into the body, the lesions it causes and the bearing which these features have on symptomatology, diagnosis, prevention, and treatment.

Paper No. 15:

Some Basic Contributions of Experimental Poliomyelitis to Our Knowledge of the Human Problem—E. W. Schultz, M.D., Stanford University School of Medicine, San Francisco.

A summary of the fundamental aspects of poliomyelitis as gathered from studies of the experimental disease, with special reference to its pathogenesis and the problems it presents from the standpoint of the treatment and the prevention of the acute disease.

Paper No. 16:

Symptomatology and Differential Diagnosis in Poliomyelitis—Albert G. Bower, M.D., Clinical Professor of Medicine, University of Southern California Medical School, Los Angeles.

The criteria for the recognition of the preparalytic (abortive) case of poliomyelitis and the evaluation of the spinal-fluid findings. Consideration of the carrier problem. A discussion of the relationship of the pathology and spinal-fluid findings.

Paper No. 17:

The Treatment of Poliomyelitis—Edward B. Shaw, M.D., 384 Post Street, San Francisco.

Our practical knowledge of the treatment of this disease is mostly concerned with the support of damaged muscles, the prevention of contractures, the maintenance of respiration and other vital functions, the maintenance of complete bodily rest, and measures to facilitate the restoration of function.

Serum treatment is a matter of great theoretical interest; it is our only approach, whether effective or not, to specific therapy.

Note.—At the conclusion of the symposium a motion picture film on poliomyelitis will be shown. This film has been prepared by Albert G. Bower, M.D., of Los Angeles, and shows methods of diagnosing in the admitting room; hospital treatment after the diagnosis is completed, including the respirator and respirator room; postquarantine orthopedic hospital warm pool, and physical therapy treatments.

Fifth Meeting

Thursday, May 4, 8:30 a. m.

SYMPOSIUM ON DISEASES OF THE GASTRO-INTESTINAL TRACT

Paper No. 18:

The Viscerospinal Syndrome and Its Relation to the Alimentary Tract—Neville T. Ussher, M.D., The Santa Barbara Clinic, Santa Barbara.

Some new observations of the "viscerospinal syndrome" in relation to particular sections of the alimentary tract. Studies and treatment of two hundred patients included in this group are summarized. A description is given of the nervous mechanism of the syndrome and its application to the observed cardiospasm, pylorospasm, colic, and spastic constipation.

Discussion by Gordon E. Hein, M.D., San Francisco; F. M. Pottenger, M.D., Monrovia.

Paper No. 19:

Diagnostic Value of Gastroscopy—Allan L. Cohn, M.D., 450 Sutter Street, San Francisco.

Gastroscopy with the flexible gastroscope is a simple, safe procedure facilitating the study of the stomach interior. Its value is demonstrated by colored lantern slides in the following conditions: (1) chronic superficial, hypertrophic and atrophic gastritis; (2) early diagnosis of carcinoma; (3) ulcer, (*a*) localization, (*b*) aid in therapeutic management, (*c*) differential diagnosis between benign and malignant ulcer; (4) postoperative stomach.

Discussion by L. R. Chandler, M.D., San Francisco; Fred Kruse, M.D., San Francisco.

Paper No. 20:

Recent Advances in Treatment of Hematemesis and Melena—Grant H. Lanphere, M. D., 1908 Wilshire Boulevard, Los Angeles. (Lantern demonstration.)

Pathologic anatomy of morbid changes at site of hemorrhage. Immediate diagnosis of cause of bleeding not necessary, since initial treatment is the same, no matter the source. Classification of bleeding according to severity. Intrinsic gastro-intestinal lesions caused hematemesis in majority of patients. Results of Meulengracht regimen as a means to reduce mortality from acute hemorrhage.

Discussion by William C. Boeck, M.D., Los Angeles; Clarence J. Berne, M.D., Los Angeles.

Paper No. 21:

The Efficacy of Liver Extract in the Treatment of Ulcerative Colitis—Garnett Cheney, M. D., 210 Post Street, San Francisco.

Consideration of causative factors in idiopathic ulcerative colitis; susceptibility of colon to ulceration; allergy; infection; and nervous system influences. Clinical types of ulcerative colitis. Failure of usual modes of therapy. Results obtained with parenteral liver extract in treating twenty-five cases followed from six to eighteen months.

Discussion by Eugene L. Armstrong, M.D., Los Angeles; Edwin L. Bruck, M.D., San Francisco.

Paper No. 22:

The Gall-Bladder in Relation to Chronic Arthritis of Unknown Etiology—Robert S. Peers, M.D., 2939 Summit Street, Oakland.

A study of gall-bladder pathology as determined by x-ray visualization in relation to the onset, progress, prognosis and response to treatment in chronic arthritis of unknown etiology.

Discussion by A. A. Alexander, M.D., Oakland; Edward W. Boland, M.D., Los Angeles.

II

GENERAL SURGERY

Loren R. Chandler, M.D., *Chairman*
Stanford University Medical School, San Francisco
Ray B. McCarty, M.D., *Secretary*
Mission Inn Rotunda, Riverside
Frederick S. Foote, M.D., *Assistant Secretary*
Dante Hospital, San Francisco

First Meeting

Monday, May 1, 1:30 p. m.

Symposium on Sulfanilamid

This will be a joint meeting with the General Medicine Section.

Already Listed as Paper No. 1.

Pharmacology of Sulfanilamid and Related Compounds—Windsor C. Cutting, M.D., Department of Pharmacology, Stanford Medical School, and William L. Cover, M.D., San Bernardino.

Sulfanilamid, neoprontosil, and sulfapyridin will be compared briefly chemically and in their general effects on bacteria. The controversy concerning the mode of action, and the differences in absorption, distribution, excretion, toxicity, and therapeutic use will be discussed in some detail.

Already Listed as Paper No. 2.

Sulfanilamid and Sulfapyridin in the Treatment of Various Infections—Chester S. Keefer, M. D., Associate Professor of Medicine, Harvard Medical School, Boston, Mass. (By invitation.)

The results of the use of sulfanilamid in the treatment of hemolytic streptococcal, gonococcal, meningococcal, and urinary-tract infections will be summarized, and its mode of action and toxic effects will be discussed. A new derivative of sulfanilamid, sulfapyridin, has been used for the treatment of pneumococcus pneumonia. The present status of this drug will be reviewed. Its indications, mode of action, and side effects will be stressed.

Already Listed as Paper No. 3.

Urological Uses of Sulfanilamid—Bernard Silver, M.D., 1712 North Highland, Hollywood.

In the three years since the introduction of sulfanilamid in urologic practice its efficacy in gonorrhea has been established in many large series of cases, but despite this, its effect on the total incidence of gonorrhea has been apparently small.

In nonspecific infections of the upper urinary tract, sulfanilamid is more effective than all previous antiseptics, but it is an adjunct to mechanical urologic procedures, because without removal of obstructive factors the infection has either failed to respond or the infection has promptly recurred after its discontinuance.

Already Listed as Paper No. 4.

Sulfanilamid in Surgical Practice—Arthur Haim, M.D., 450 Sutter Street, San Francisco.

Discussion of the use of sulfanilamid compounds in conditions met with in surgical practice, with special emphasis on indications and contra-indications. Lantern slides will illustrate the immunobiologic mangement of a series of severe hemolytic streptococcus infections in which chemotherapy was used.

Discussion by William Mitchell, M.D., Los Angeles; Edgar Wayburn, M.D., San Francisco; Clayton Lyon, M.D., San Francisco; Shuler F. Fagan, M.D., Los Angeles.

Second Meeting

Tuesday, May 2, 8:30 a. m.

Paper No. 23:

Chairman's Address: Imperforate Anus and Its Surgical Treatment—Loren R. Chandler, M.D., Stanford University Medical School, San Francisco.

The embryology concerned in the formation of the imperforate anus and congenital fistulae from the bowel to the genito-urinary tract is presented. The clinical features of the conditions, aids to diagnosis, and the surgical treatment are discussed. It is pointed out that control of the intestine can be obtained without preservation of the external anal sphincter, provided the function of the levätor ani muscles is preserved. Five cases are reported.

Paper No. 24:

Duodenal Obstruction of Congenital Origin—Harold H. Lindner, M.D., 490 Post Street, San Francisco; and John B. DeC. M. Saunders, F.R.C.S. (Ed.), University of California Hospital, San Francisco. (By invitation.)

As a result of a recent study of cases illustrating congenital duodenal valve formation, stenosis and malposition, the authors, following a preliminary discussion of existing views, offer new embryologic evidence of etiologic correlation with congenital obstructive lesions occurring elsewhere in the intestines. Clinical diagnosis and treatment of these conditions are discussed.

Discussion by Jacob Smith, M.D., San Francisco; Philip M. Savage, Sr., M.D., San Bernardino.

Business Recess

Business meeting and election of officers.

Paper No. 25:

The Surgical Treatment of Diseases of the Extra Hepatic Biliary Tract—Philip J. Cunnane, M.D., 1052 West Sixth Street, Los Angeles.

An analysis of two hundred consecutive cases. An evaluation of diagnostic procedures and preoperative preparatory measures. Pathology encountered and its operative treatment. Comparative results of conservative and emergent treatment of acute cholecystic disease. Postoperative care, mortality, and morbidity.

Discussion by Walter A. Bayley, M.D., Los Angeles; Stanley H. Mentzer, M.D., San Francisco.

Paper No. 26:

Diverticulitis of the Colon—Clarence J. Berne, M.D., 1136 West Sixth Street, Los Angeles, and A. C. Pattison. M.D.. 595 East Colorado Street, Pasadena.

This is a study of the surgically important complications of diverticulosis of the colon seen at the Los Angeles General Hospital since 1930. The complications particularly considered are acute infection, stricture, and fistula. Particular consideration will be given to the relative value of conservative and operative treatment of the acute cases, with an evaluation of the various operative procedures.

Discussion by Dudley V. Saeltzer, M.D., Sacramento; Meredith G. Beaver, M.D., Redlands.

Paper No. 27:

The Use of Antiseptics in Colon Surgery—Clarence E. Rees, M.D., Rees-Stealy Clinic, San Diego.

Various antiseptics were injected into the loops of the colons of animals and their efficacy determined by means of cultures. The work may form a basis for a technique to be used in colon surgery, whereby the infectiousness of the colon contents will be reduced and

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Section Aides: Carleton Mathewson, Jr., M.D., San Francisco; Robert Scarborough, M.D., San Francisco; Newman K. Bear, M.D., Riverside; Martin W. Debenham, M.D., San Francisco.

the incidence of peritonitis resulting therefrom correspondingly lessened.

Discussion by Carleton Mathewson, Jr., M.D., San Francisco; Caleb S. Stone, Jr., M.D., Santa Barbara.

Paper No. 28:

Intestinal Obstruction Incident to Acute Appendicitis—Calvin A. Lauer, M.D., 117 East Eighth Street, Long Beach; and Harold Totten, M.D., 8224 South Broadway, Los Angeles.

Ten years of consecutive intestinal obstruction cases incident to appendicitis treated at Los Angeles General Hospital.

A study is made of the effect on the incidence of obstruction by the following factors: Type of appendiceal pathology, and the treatment used, including type of incision and drainage methods, and accessory procedures.

Discussion by George D. Brown, M.D., Pomona.

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Third Meeting

Wednesday, May 3, 8:30 a. m.

SYMPOSIUM ON CARCINOMA OF THE BREAST

This will be a joint meeting with the Radiology Section.

Paper No. 29:

The Spread of Breast Cancer—Eric Liljencrantz, M.D., Stanford University Hospital, San Francisco.

Distribution of metastases, in a thousand patients dying with carcinoma has been studied. Breast carcinoma has been found to spread more widely than any other epithelial tumor. Its paths of metastases have been traced, representative material collected. This is presented to illustrate problems which must be faced in clinical management.

Paper No. 30:

Borderline Intraductal Hyperplasias of the Breast—Alson R. Kilgore, M.D., 490 Post Street, San Francisco.

Overgrowths within ducts cause rise to persistent disagreement among pathologists. Probably most examples are benign and remain so, but some are certainly precancerous. Diagnostic significance of nipple erosion and discharges. (Illustrative cases.)

Paper No. 31:

Surgical Treatment of Carcinoma of the Breast—Stuart W. Harrington, M.D., Mayo Clinic, Rochester, Minn. (By invitation.)

Recognition of malignant disease of the breast by clinical signs and symptoms depends on the duration of the lesion at the time of examination; these signs and symptoms are hopelessly inadequate in determining early malignant disease.

There are many factors which influence prognosis, the most important of which are the type of malignant disease which is present, the degree of malignancy as shown by the microscopic examination of the tissue, the age of the patient, the presence of other conditions such as diabetes, exophthalmic goiter, etc., the extent of the disease at the time of operation, and the thoroughness with which the radical operation is done. The following studies and results of operation are based on a series of 5,105 cases in which the patients were operated on in the period of 1910–1935, inclusive.

Discussion by H. Glenn Bell, M.D., San Francisco; Verne C. Hunt, M.D., Los Angeles; Robert E. Stone, M.D., San Francisco; Lyell C. Kinney, M.D., San Diego.

Paper No. 32:

Treatment of Carcinoma of the Breast from the Standpoint of the Radiologist—U. V. Portmann, M. D., Cleveland Clinic, Cleveland, Ohio. (By invitation.)

Discussion by Robert E. Stone, M.D., San Francisco; Lyell C. Kinney, M.D., San Diego.

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Fourth Meeting

Wednesday, May 3, 1:30 p. m.

Paper No. 33:

Experimental Production of Breast Lesions by Injection of Gonadotropic and Estrogenic Hormones—Nelson J. Howard M.D., 350 Post Street, San Francisco.

Normal growth and development of the breast in rats. Pathologic states of the rat breast produced by chronic hormone injections. The relation of hormones to pathologic changes encountered in human breast tissue; infantile, adolescent and adult. Chronic mastitis, benign, fibro-adenoma, and cancer.

Discussion by Henry J. Ullmann, M.D., Santa Barbara; Alson R. Kilgore, M.D., San Francisco.

Paper No. 34:

Beyond the Thyroid—Conrad J. Baumgartner, M.D., 523 West Sixth Street, Los Angeles.

Technical hazards of thyroidectomy are: (1) Hemorrhage. (2) Recurrent laryngeal nerve injury. (3) Parathyroid injury. These hazards are greatly obviated by full knowledge of the anatomy of the region of the thyroid. This presentation demonstrates a telescopic view, motion picture in color of an anatomical dissection of the region about the thyroid.

Discussion by George Thomason, M.D., Los Angeles; Wallace Terry, M.D., San Francisco.

Paper No. 35:

Modern Methods of Aiding Wound Healing—Hall G. Holder, M.D., 233 A Street, San Diego; and Eaton M. McKay, M.D., 476 Prospect Street, La Jolla.

Removal of necrosis and débris from wounds. Effect of urea experimentally and clinically. Blood supply. Experimental demonstration of deleterious effects of germicidal agents on granulation tissue and epithelialization. Consideration of epithelializing agents. Experimental and clinical use of thio-urea.

Discussion by Leighton Ray, M.D., Santa Rosa; John M. Schmoele, M.D., Los Angeles.

Paper No. 36:

Uses of Staphylococcus Toxin and Antitoxin in General Surgery—Charles Weiss, Ph.D., M.D., Mount Zion Hospital, San Francisco.

A review of newly developed knowledge concerning the immunology of staphylococcus toxin and its rôle in surgical infections. Methods measuring immunity in patients. Experiences with staphylococcus toxin and antitoxin in the treatment of staphylococcus septicemia, boils, osteomyelitis, etc. The absorption and elimination of antistaphylococcus antibody. The combined use of antitoxin and sulfanilamid.

Discussion by Robert P. Sutherland, M.D., Oakland; Albert G. Bower, M.D., Glendale.

Paper No. 37:

Skin Grafting: With Report of New Procedure—Arthur E. Smith, M.D., D.D.S., 1930 Wilshire Boulevard, Los Angeles, and James B. Johnson, M.D., 1930 Wilshire Boulevard, Los Angeles.

The presentation will consist of a brief consideration of the various methods of skin grafting and their relative merits. Special attention will be paid to the subdermal implant method, which we believe to be original, and to a method of removing split skin of desired calibration. Most of the allotted time will be consumed in illustrating various methods by colored motion pictures, depicting the surgical procedure of several cases.

Discussion by E. Eric Larson, M.D., Los Angeles; George Warren Pierce, M.D., San Francisco.

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Fifth Meeting

Thursday, May 4, 8:30 a. m.

Paper No. 38:

Cancer of the Nasopharynx and Maxillary Sinus with Treatment—James F. Percy, M.D., 1030 South Alvarado Street, Los Angeles.

This paper is based on fifty cautery operated patients with advanced and otherwise hopeless cancer and sarcoma of the nasopharynx and maxillary antrum. All had previously been treated by various methods and abandoned. What constituted advanced cancer of this region of the body is related; pathology and treatment are described. Cautery will be demonstrated.

Discussion by Thomas F. Mullen, M.D., San Francisco; Franklyn D. Hankins, M.D., Riverside.

Paper No. 39:

Polypoid Bronchial Tumors—Alfred Goldman, M.D., University of California Hospital, San Francisco.

Polypoid bronchial tumors are of three types—carcinomatous, adenomatous, and a large group of several histologic types which are often confused with adenomata. The differentiation of adenomtata, comprising approximately 10 per cent of all bronchial tumors from carcinomata has given to medicine a curable bronchial tumor previously thought to be fatal.

Discussion by Leo Eloesser, M.D., San Francisco; John G. Jones, M.D., Los Angeles.

Paper No. 40:

Papaverin Hydrochlorid in the Treatment of Mesenteric Thrombosis—Leo J. Madson, M. D., 710 Wilshire Boulevard, Los Angeles.

A case report is cited of mesenteric thrombosis proved by surgery and treated by intravenous papaverin hydrochlorid, with recovery.

The paper presents a proved case of mesenteric thrombosis which has been successfully treated medically; urges the use of papaverin hydrochlorid in the field of obstructive mesenteric thrombosis.

Discussion by Donald C. Collins, M.D., Los Angeles; William Whitfield Crane, M.D., Oakland.

Paper No. 41:

Pharyngo-esophageal Diverticula—John Hunt Shephard, M.D., 609 Medico-Dental Building, San Jose.

A short review of the symptoms and diagnosis; comments on the present-day accepted operative procedures; and a description of a modified, one-stage technique.

Discussion by Charles Roller, M. D., Woodland; Francis B. Settle, M. D., Long Beach.

Paper No. 42:

Treatment of Varicose Veins—S. H. Babington, M.D., 2301 Ward Street, Berkeley.

Causes of varicose veins; methods of therapy from earliest to the present time; injection method—pros. and cons; contra-indications for injection; tests for suitability prior to injection; untoward reactions and how to avoid them; review of results of about five thousand injections at Oakland Health Center and in private practice.

Discussion by John Louis Lohse, M.D., Oakland; Stanton Sherman, M.D., San Francisco.

III

OBSTETRICS AND GYNECOLOGY SECTION

George W. Coon, M.D., *Chairman*
3770 Twelfth Street, Riverside

John N. Ewer, M.D., *Vice-Chairman*
411 Thirtieth Street, Oakland

William Benbow Thompson, *Secretary*
1930 Wilshire Boulevard, Los Angeles

First Meeting

Monday, May 1, 1:30 p. m.

Paper No. 43:

Hyperemesis Gravidarum: A Clinical Study of One Hundred and Twenty Cases Treated by Suprarenal Cortex and Vitamin B_1 Preparations—Abraham Bernstein, M.D., 390 Post Street, San Francisco.

Of one hundred and twenty cases of nausea and vomiting of pregnancy, 10.8 per cent were severe, 6.6 per cent were reflex, and the rest were moderate in character. The entire group was treated with suprarenal cortex and vitamin B_1 after other methods had failed. The results and rationale of treatment are carefully discussed.

Discussion opened by Alice F. Maxwell, M.D., San Francisco.

Paper No. 44:

Menstrual Disturbances of the Climacteric with Endometrial Findings—Gertrude Flint Jones, M. D., 490 Post Street, San Francisco.

A study of the four types of endometrium from which bleeding at the climacteric and before the menopause may take place, *i. e.*, secretory, proliferative, hyperplastic, and atrophic. An attempt has been made to discover a relationship between the type of endometrium, the character of the bleeding and the symptom of hot flushes, and/or the appearance of APH in the blood. The histology of endometrium found in bleeding cases at this period should logically influence the choice of therapy.

Discussion by Charles Frederick Fluhmann, M.D., San Francisco; Samuel J. Glass, M.D., Los Angeles.

Paper No. 45:

The Use of Equine Gonadotropic Serum in Gynecology—George Joyce Hall, M.D., 626 Medico-Dental Building, Sacramento.

Derivation and "what is it?" Effects on laboratory animals (very short notation). Clinical application in such conditions as: amenorrhea, primary and secondary; hypomenorrhea; dysmenorrhea; menorrhagia; hypogonad conditions; sterility (functional); menopause—no effect. Case histories. Summarization of statistics of results. Comments. Conclusions. (Lantern demonstrations.)

Discussion by L. F. Hawkinson, M.D., Oakland; Sheldon Payne, M.D., Los Angeles.

Paper No. 46:

Pediatric Gynecology—Goodrich C. Schauffler, M.D., 548 Medical Arts Building, Portland. (By invitation.)

This discussion will include: (1) Psychologic factors; (2) special methods of examination; (3) differential factors between the immaturity and maturity in relation to anatomy and physiology; (4) detailed consideration of management—of affections of: (*a*) vulva; (*b*) clitoris; (*c*) hymen; (*d*) rectum (*e*) va-

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Section Aides: R. Glenn Craig, M.D., San Francisco; Erle M. Henriksen, M.D., Los Angeles.

gina; (*f*) cervix; (*g*) tubes, ovaries, and pelvic peritoneum.

Discussion by Frank W. Lynch, M.D., San Francisco.

Paper No. 47:

Hysterectomy for Chronic Salpingitis—John C. McDermott, M.D., 1930 Wilshire Boulevard, Los Angeles.

Salpingectomy alone is frequently performed for chronic salpingitis. In a large number of cases following this procedure, irregular, prolonged, and profuse uterine bleeding develops, and a hysterectomy becomes necessary. It is, therefore, suggested that subtotal hysterectomy should accompany the salpingectomy.

Discussion by Philip H. Arnot, M.D., San Francisco; William Buster McGee, M.D., San Diego.

Paper No. 48:

Rupture of Membranes Prior to Onset of Labor: Results of Stimulation of Contractions—Raymond D. McBurney, M. D., 825 South Alvarado Street, Los Angeles.

Rupture of the membranes prior to the onset of labor. A comparison of the management and results obtained in two series representing clinic and private cases. Data and discussion concerning the difficulties met with in those cases where the onset of labor is prolonged more than six hours following rupture of the membranes.

Discussion by Margaret Schulze, M.D., San Francisco.

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Second Meeting

Wednesday, May 3, 8:30 p. m.

Paper No. 49:

Major Complications Encountered in a Study of Nine Thousand Three Hundred Ninety-Four Obstetrical Cases at the University of California Hospital—P. L. Martin, M.D., University of California Hospital, San Francisco.

This study is based on twenty-two years of obstetrical experience in the University of California Hospital. The relative rôles of the pelvis, the pains and the position, are studied in difficult labors. The sequelae of cesarean section are compared with those from operative delivery by the vaginal route. Toxemia, heart disease and diabetes with pregnancy are studied. The results of a general plan of conservative obstetrical management are evaluated in terms of fetal and maternal mortality.

Discussion by Charles Harold Lewis, M.D., Santa Monica.

Paper No. 50:

Aspiration Pneumonitis: A Factor in Maternal Morbidity—Charles C. Hall, M.D., 411 Thirtieth Street, Oakland.

The author reports a case in which a patient vomited during the course of a gas anesthetic for low forceps delivery, and died thirteen days later. Autopsy showed a very extensive pneumonitis probably of a chemical nature. The possibility of such an occurrence is referred to in the standard books on anesthesia, but a careful search of the medical literature failed to reveal a single case, reported in any detail. Without much difficulty, however, the author has collected several cases by inquiring among his associates, so that he is convinced that the condition is not rare, though rarely fatal. This paper tries to study these collected cases and ascertain why the incident occurs; what the nature of the pathologic lesion is, whether this accident can be prevented, and how the condition can be treated.

Discussion by Philip H. Pierson, M.D., San Francisco; Karl Schaupp, M.D., San Francisco.

Business Recess

Business meeting and election of officers.

Paper No. 51:

Chairman's Address: The Patient's Concept of Maternity Care and Obstetrical Anesthesia as Obtained from Popular Sources—George W. Coon, M. D., 3770 Twelfth Street, Riverside.

A critical review of recent popular magazine articles on prenatal care and anesthesia, and of available free literature on these subjects, along with a résumé of questionnaires sent to past maternity patients, in an endeavor to obtain their reactions to various obstetrical procedures and preferences of anesthesia.

Paper No. 52:

Studies in Sterility: The Results in Five Hundred Cases—Erle Henriksen, M.D., 523 West Sixth Street, Los Angeles.

Brief summarization of the innumerable etiologic items accounting for sterility in five hundred couples. No routine for treatment of sterility; emphasis on appraising male fertility before advising possible unwarranted treatment in the female. Complicated routines requiring elaborate equipment replaceable by competent clinical study and intelligent recognition of possible causative factors.

Discussion by R. Glenn Craig, M.D., San Francisco; W. K. Lamb, M.D., Berkeley.

Paper No. 53:

Comparative Results of the Various Contraceptive Techniques—Nadina R. Kavinoky, M.D., 1930 Wilshire Boulevard, Los Angeles.

The comparative results of various contraceptive techniques will be discussed. Comment on the studies made from records in the contraceptive clinics. An analysis is also made of the factors which contribute to increasing the efficiency of the standard methods, together with factors involved where the methods failed. The newer contraceptives will be discussed. (Lantern demonstration.)

Discussion by Henry A. Stephenson, M. D., San Francisco.

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IV

EYE, EAR, NOSE, AND THROAT SECTION

Clifford Walker, M.D., *Chairman*
427 West Fifth Street, Los Angeles
Harry Wiley, M.D., *Vice-Chairman*
2701 Florence Avenue, Huntington Park
Dewey R. Powell, M.D., *Secretary*
501 Medico-Dental Building, Stockton

First Meeting

Monday, May 1, 1:30 p. m.

Paper No. 54:

The Effect of Orthoptic Training on the Reading Ability—C. A. Broaddus, M.D., 905 Medico-Dental Building, Stockton.

The object of all orthoptic training is to give the patient more comfort in reading and at the same time to increase his speed and comprehension. Heretofore, we have not had accurate means of determining the patient's reading ability before treatment nor any way of measuring his improvement from such treatment or exercise. In this paper such methods are described and their results demonstrated.

Discussion by Avery Hicks, M.D., San Francisco.

Section Aide: Harry Wiley, M.D., Huntington Park.

Paper No. 55:

Optical Keratoplasty: An Evaluation—Max Fine, M.D., 490 Post Street, San Francisco.

The reported results of corneal transplantation by various authors display a great discrepancy due largely to lack of standardization of terms, but due also to differences in technique and in the selection of cases. The indications for the operation are now well defined and a statistical basis for prognosis is now available. The author gives reasons for believing that the most efficient technique is a modification of the operation of Castroviejo, using two corneal sutures for fixation of the graft. Two cases of permanently successful transplantation by this method are described.

Discussion by David Harrington, M.D., San Francisco.

Paper No. 56:

Vitamin A Deficiency in Asthenopia—Frederick C. Cordes, M.D., and David O. Harrington, M.D., 384 Post Street, San Francisco.

The paper presents a brief review of vitamin A and its relation to the eye. In addition, it reports a series of approximately eighty cases with asthenopia and low biophotometer readings. In a very high percentage of these cases symptoms were relieved by the administration of carotene.

Discussion by Hans Barkan, M.D., San Francisco.

Paper No. 57:

Cornea Plana: Complicated by Glaucoma—Harold F. Whalman, M.D., 1147 Roosevelt Building, Los Angeles.

A description of this condition is given, with references to the literature on the subject. The frequent occurrence of glaucoma as a complication to this anatomical anomaly is supported by a case report of a young woman who came under the observation of the essayist three years ago. Pilocarpin has adequately controlled tension and fields since that time.

Discussion by Hans Barkan, M.D., San Francisco.

Paper No. 58:

Interesting Ocular Muscle Conditions—Roderic O'Connor, M.D., 1904 Franklin Street, Oakland.

A series of reports of interesting muscle conditions is presented with comments thereon.

Discussion by George Hosford, M.D., San Francisco.

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Second Meeting

Tuesday, May 2, 8:30 a. m.

Paper No. 59:

Chronic Nonhealing Lesions of the Nose—Russell Fletcher, M.D., Medico-Dental Building, San Francisco.

Occasionally one encounters lesions in the nose which do not respond to the usual methods of treatment. The differential diagnosis may be difficult, necessitating biopsy. The treatment depends upon the diagnosis. Report of cases diagnosed by biopsy as tuberculosis and/or sarcoid.

Discussion by Matthew Hosmer, M.D., San Francisco.

Paper No. 60:

Problems of the Hard of Hearing: Committee Report—Francis L. Rogers, M.D., 360 Junipero Avenue, Long Beach.

Review of objectives and accomplishments of the Committee on Problems of the Hard of Hearing for 1934–1939, and consideration of the future plans. Approximately 720,000 handicapped citizens of California who are deafened present economic problems. Deafness as a factor in juvenile delinquency. Standardization of audiometric tests. Part that otologists should play in the problem of the hard of hearing.

Discussion by Roy Jones, M.D., Sacramento.

Business Recess

Business meeting and election of officers.

Paper No. 61:

Osteomyelitis of the Frontal Bone—Lewis F. Morrison, M.D., 490 Post Street, San Francisco.

Report of two cases, lantern slides, and discussion of the methods of treatment.

Discussion by R. C. Martin, M.D., San Francisco.

Paper No. 62:

Relief of Neuritis of the Eighth Cranial Nerve with Vitamin B_1—K. C. Brandenburg, M.D., 110 Pine Avenue, Long Beach.

A short review of the important facts concerning methods of administration, dosage, excretion, storage, toxicity, and sources of vitamin B_1 will be accompanied by the report of a case of severe tinnitus, following extensive irradiation for carcinoma of the cervix uteri, relieved by treatment with thiamin chlorid. Other possible applications of this form of therapy in neuritis of the cranial nerves will be suggested.

Discussion by Dewey R. Powell, M.D., Stockton.

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Third Meeting

Wednesday, May 3, 1:30 p. m.

SYMPOSIUM ON HEADACHES

Paper No. 63:

Headaches, from the Standpoint of the Internist—Dwight L. Wilbur, M.D., and Lindol R. French, M.D., 490 Post Street, San Francisco.

In this paper will be considered the etiology, mechanism of production, the clinical and diagnostic features of common chronic headaches, such as those of the rheumatic, toxic, reflex, vascular, psychoneurotic and migrainous type.

Paper No. 64:

Headaches, from the Standpoint of the Neurologist—O. W. Jones, Jr., M.D., 384 Post Street, San Francisco.

"Headache of Intracranial Origin." A discussion of various intracranial disorders of which headache is a common symptom.

Paper No. 65:

Headaches, from the Standpoint of the Ophthalmologist—W. D. Horner, M.D., 490 Post Street, San Francisco.

Headaches in ophthalmic practice are common, being only exceeded by defective vision as a major complaint. The characteristics of these headaches are discussed. Their mechanism is reviewed as referred pain through the fifth and sympathetic nerves and from local disorders of the extra-ocular muscles, accommodation, retinal function, and congestive states.

Paper No. 66:

Headaches, from the Ear, Nose, and Throat Standpoint—Herbert J. Cohn, M.D., 450 Sutter Street, San Francisco.

History of complaint, causes, location, symptomatic determination. Coexistence of other diseases. Specific localization. (1) Frontal; (2) Lateral; (3) Occipital; (4) Vertex.

Suppurative and nonsuppurative type. Intracranial and extracranial causes. General remarks.

Discussion of the above papers by Edmund J. Morrissey, M.D., San Francisco; C. B. Courville, M.D., Los Angeles; Russell Fletcher, M.D., San Francisco; S. P. Lucia, M.D., San Francisco.

V

ANESTHESIOLCGY SECTION

John G. Dunlop, M.D., *Chairman*
168 South Kingsley Drive, Los Angeles
Adena C. Dutton, M.D., *Secretary*
2400 Pacific Avenue, San Francisco

First Meeting

Monday, May 1, 1:30 p. m.

Paper No. 67:

Chairman's Address: Anesthetic Practices in Thoracic Surgery—John G. Dunlop, M.D., 168 South Kingsley Drive, Los Angeles.

This report is based upon personal communications with thoracic surgeons and anesthetists at the larger medical centers in this and other English-speaking countries.

Preoperative preparation and medication, the anesthetic agents and techniques preferred, and the methods employed to minimize the danger of spread of infection throughout the lungs, are discussed.

Paper No. 68:

Anesthetic Technique in Plastic Surgery of the Head and Neck—A. J. Wineland, M.D., 338 South Saint Andrews Place, Los Angeles.

A presentation of the author's experience with closed endotracheal anesthesia in reconstructive and general surgery of the head and neck during the past ten years. The advantages of this technique to the operating team and patient will be discussed.

Discussion by Albert Davis, M.D., San Francisco; John A. Stiles, M.D., San Francisco. (By invitation.)

Paper No. 69:

Nitrous Oxid Anesthesia—Philip K. Gilman, M.D., 2000 Van Ness Avenue, San Francisco.

Preliminary considerations, secret of satisfactory anesthesia, teamwork among members of the operating group, preparation of the patient, handling and position of the patient before, during and after operation, relaxation, shock, fluids, opiates, advantages and difficulties of nitrous oxid anesthesia, statistical data—fifteen years' experience, and conclusions.

Discussion by Ehler H. Eiskamp, M.D., Santa Cruz; Emelie Anderson, M.D., San Francisco.

Paper No. 70:

Trichlorethanol: Animal Experimentation—Evelyn Hart Case, M.D., Department of Anesthesia, Stanford University School of Medicine, San Francisco.

Preliminary report on the use of trichlorethanol in animals. A comparative study was made of the effective and toxic dosage of trichlorethanol and tribromethanol, given intraperitoneally to rats. Results of pathologic examinations, of those dying from large doses after repeated increasing doses of the drugs are included.

Discussion by Maurice L. Tainter, M.D., San Francisco.

Paper No. 71:

A Plea for the Accurate Rating of Anesthetics—Paul Campiche, M.D., 450 Sutter Street, San Francisco.

To appraise accurately the value of various anesthetics, the author proposes a method of "rating" based on the combined opinions of competent anesthetists and expressed by a single figure, making rapid comparison possible. The ideal general anesthetic is described and a possible method of achieving it is discussed.

Discussion by Dorothy Wood, M.D., San Francisco.

Second Meeting

Tuesday, May 2, 8:30 a. m.

Paper No. 72:

Spinal Anesthesia—Leo L. Stanley, M.D., San Quentin.

In twenty-five years at San Quentin, 220 operations were performed with inhalants, and 4,674 with spinal anesthesia. Dosage of procain ranged from one and one-half to four grains, according to the operation. Ephedrin was the only preoperative medication. There were three deaths, only one of which was attributed directly to spinal anesthesia. Administration, complications, duration of anesthesia, are discussed.

Discussion by Lloyd R. Reynolds, M.D., San Francisco; Reginald F. Grant, M.D., San Francisco.

Paper No. 73:

Subarachnoid Block: "Saddle Area" Distribution—Edward H. Bolze, M.D., 516 Sutter Street, San Francisco.

Introduction, definitions, anatomy; technique of administration and drugs used. Report of 150 minor rectal operations where this type of anesthesia was used and conclusions are given.

Discussion by David Susnow, M.D., San Francisco; Robert Scarborough, M.D., San Francisco; M. J. Groper, M.D., San Francisco; Jacob Smith, M.D., San Francisco.

Business Recess

Business meeting and election of officers.

Paper No. 74:

Pentabarbital Sodium—Nembutal—in Obstetric Analgesia—Gwendolyn Campion, M.D., 909 Hyde Street, San Francisco.

Pharmacology, physiologic action and toxicity; requirements of an obstetrical analgesic; effects noted on analgesia, excitement or restlessness, condition of child, type of delivery, length of labor; short review of the literature and comparison of findings.

Discussion by Donald A. Dallas, M.D., San Francisco; Ethel Righetti, M.D., San Francisco.

Paper No. 75:

Management of Senile Patients for Anesthesia and Operation—Walter Lawrence, M. D., 54 Brentwood Avenue, San Francisco.

A regimen is suggested for the preoperative care, premedication, anesthesia, and postoperative management of senile surgical patients, which should aid in reducing the mortality rate in such cases. A review of a series of surgical prostate and fracture cases is presented to illustrate the regimen described.

Discussion by George McChesney, M.D., San Francisco; Lionel Player, M.D., San Francisco.

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VI

DERMATOLOGY AND SYPHILOLOGY SECTION

Norman N. Epstein, *Chairman*
450 Sutter Street, San Francisco
Franklin I. Ball, *Vice-Chairman*
6253 Hollywood Boulevard, Hollywood
Arne E. Ingels, *Secretary*
490 Post Street, San Francisco

First Meeting

Monday, May 1, 1:30 p. m.

Paper No. 76:

Chairman's Address: The Present Status of Artificial Fever in the Treatment of Syphilis—Norman N. Epstein, M.D., 450 Sutter Street, San Francisco.

Section Aides: Edwin H. Keeley, M.D., San Diego; David N. Treweek, M.D., West Hollywood; Harry J. Smith, M.D., Oakland; Karolina B. Jump, M.D., San Mateo.

Section Aides: Charles Albert Shumate, M.D., San Francisco; Herman V. Allington, M.D., Oakland.

Paper No. 77:

Treatment of Dermatophytosis—Harry E. Alderson, M.D., 490 Post Street, San Francisco.

General considerations; general care of patient; local care of lesions; after-care and prophylaxis.

Discussion by Hiram E. Miller, M.D., San Francisco; Merlin Maynard, M.D., San Jose.

Paper No. 78:

Public Health Measures in Combating Syphilis—Malcolm H. Merrill, M.D., State Department of Public Health, Civic Center, San Francisco.

The present official syphilis control program in California will be summarized. The administrative machinery will be described, the main objectives of the program discussed. Statistics on reporting, clinic activities, assistance to private physicians, laboratory services and educational activities will be given. The relationship between the health departments and private physicians will be discussed.

Discussion by Howard Morrow, M.D., San Francisco; Walter Dickie, M.D., San Francisco (by invitation); Harry J. Templeton, M.D., Oakland.

Paper No. 79:

Pigmented Eruptions Occurring in Patients Receiving Arsenicals and Bismuth in the Treatment of Syphilis—Irving R. Bancroft, M.D., and Chris R. Halloran, M.D., 1052 West Sixth Street, Los Angeles.

Observations taken from the study of twenty patients who developed skin eruptions while receiving arsenicals or bismuth in the treatment of syphilis. Several different types of pigmentary eruptions were observed, one type so closely simulating lichen planus as to be indistinguishable either clinically or histologically. (Lantern-slide demonstration of the various types of eruptions, together with histologic and chemical findings.)

Discussion by Frederick G. Novy, Jr., M.D., Oakland; Julius Scholtz, M.D., Los Angeles.

Paper No. 80:

Recurrent Herpetiform Dermatitis Repens — Samuel Ayres, Jr., M.D., and Nelson P. Anderson, M.D., 2007 Wilshire Boulevard, Los Angeles.

A report of a series of six cases of a hitherto undescribed clinical entity, consisting of a chronic, recurrent, superficial, spreading vesicular and undermining eruption affecting chiefly the neck, axillae, and crotch. The lesions appear spontaneously without any history of trauma or drug ingestion, and are rebellious to therapy.

Discussion by George Kulchar, M.D., San Francisco; P. K. Allen, M.D., San Diego.

Paper No. 81:

Differential Diagnosis of Keratoderma Blennorrhagicum and Psoriasis Arthropathica—Ervin Epstein, M.D., 1624 Franklin Street, Oakland.

There is a dispute in the literature as to whether these conditions are identical or not. The differential diagnosis of the two conditions may be very difficult in individual cases. However, a statistical review of a large series of recorded cases indicates certain differential points that make it seem most likely that gonorrheal keratoses and the arthropathic form of psoriasis are separate entities that can be distinguished from the standpoint of etiology, clinical and laboratory findings, prognosis, and response to different forms of therapy.

Discussion by C. Russell Anderson, M.D., Los Angeles; H. V. Allington, M.D., Oakland.

Second Meeting

Tuesday, May 2, 8:30 a. m.

Paper No. 82:

Poison Oak and Poison Ivy: "Dermatitant Units," as a Standard Measure of Potency for Extracts from these Plants—Ernest K. Stratton, M.D., 490 Post Street, San Francisco.

The dermatitant strength rather than the solids content of extracts of poison oak and poison ivy is suggested as a unit of measure, owing to the presence of varying quantities of the former in the different extracts.

Preliminary testing of the extracts is done on the skins of animals incapable of being sensitized, such as the rabbit, rat, and mouse. Ten thousand "dermatitant units," the minimum reactive dose for these animals, is determined in this manner. For use on sensitized skins, such as those of the guinea pig and human, dilutions or concentrations can then be made so that 0.1 cubic centimeter represents 10 units, 100,000 units, or any number of units between these two extremes.

Discussion by Albert H. Rowe, M.D., San Francisco; Thomas W. Nisbet, M.D., Pasadena.

Paper No. 83:

Occupational Dermatoses in the Aircraft Industry—C. Ray Lounsberry, M.D., 233 A Street, San Diego.

A three years' study of occupational dermatoses found in one of America's largest aviation manufacturing plants, the Consolidated Aircraft Corporation of San Diego, as dermatological consultant. In this study Doctor Lounsberry takes up certain allergic industrial dermatoses associated with new metals which are used in the manufacturing of airplanes.

Discussion by Kendal Frost, M.D., Los Angeles; Eric Liljencrantz, M.D., San Francisco.

Business Recess

Business meeting and election of officers.

Paper No. 84:

Fungus Infection of Eyelashes—C. J. Lunsford, M.D., 3115 Webster Street, Oakland.

R. J., boy, age seven years, came to the office because of tinea capitis. Subsequently he developed a tinea corporis and blepharitis. The loosened eyelashes were microscopically positive for fungi, and cultures of them showed microsporon lanosum. This was true of all areas affected. Discussion of treatment and review of literature.

Discussion by Frank Ball, M.D., Los Angeles; Charles Shumate, M.D., San Francisco.

Paper No. 85:

A Statistical and Pathologic Review of Thirty Cases of Melanoma Studied in the Past Twenty Years—Laurence R. Taussig, M.D., and Frances Torrey, M.D., 384 Post Street, San Francisco.

The course and eventual outcome of the group of patients with malignant melanoma seen at the University of California Dermatologic Service and in private practice. The palliative or curative effects of various types of treatment will be discussed. The relationship of the microscopic appearance to the clinical course will be noted.

Discussion by Clement E. Counter, M.D., Long Beach; Robert Stone, M.D., San Francisco.

Paper No. 86:

Tinea Capitis on the Pacific Coast—Edward A. Levin, M.D., 450 Sutter Street, San Francisco.

A study of fifty cases with microscopic and cultural findings. A description of the type of organism found predominantly on the Pacific Coast, and the relationship of this type of organism to treatment and prognosis. Based on these findings the various forms of therapeutic agents usually employed are discussed, and a simplified form outline of treatment is presented.

The exhibit will consist of photographs showing the various clinical forms of tinea capitis, photomicrographs of the appearance of the infected hairs under the microscope and gross cultures of the two chief types of ringworm, causing tinea capitis.

Discussion by Robert Stewart, M.D., San Francisco (by invitation); Otto P. Diederich, M.D., Fresno.

Paper No. 87:

Pruritus Ani and Its Relationship to Seborrheic Dermatitis and Dermatophytosis—Paul D. Foster, M.D., 2007 Wilshire Boulevard, Los Angeles, and Malcolm R. Hill, M.D., 927 West Seventh Street, Los Angeles.

It has been noted by both authors independently that a definite relationship exists between attacks of pruritus ani and an exacerbation of either seborrheic dermatitis or dermatophytosis of the feet.

It appears to us that in many cases pruritus ani is an allergic reaction from the above condition. Many cases of pruritus ani, when cultures are negative for fungi, will respond to treatment of the toxic focus without local medication. It is granted that there are many causes of pruritus ani, both of local and constitutional etiology. However, at least a majority of these cases are toxic in the same way as the dermatophytid of the hands; this latter condition is a well-recognized entity. We also know that in some severe cases the toxemia produced will cause a generalized body eruption.

This paper is for the purpose of calling to the attention of the profession that many of their persistent and exasperating cases of pruritus ani will respond only when the basic focus has been removed specifically, seborrheic dermatitis and dermatophytosis.

Discussion by Ernest D. Chipman, M.D., San Francisco; Charles Caskey, M.D., Los Angeles.

VII

INDUSTRIAL MEDICINE AND SURGERY SECTION

Harvey G. McNeil, M.D., *Chairman*
523 West Seventh Street, Los Angeles

George H. Sanderson, M.D., *Vice-Chairman*
242 North Sutter Street, Stockton

John S. Stephens, M.D., *Secretary*
1136 West Sixth Street, Los Angeles

First Meeting

Tuesday, May 2, 9:30 a. m.

Paper No. 88:

Fractured Necks of the Femur: The Simplest Method of Direct Fixation—James M. Marshall, M.D., 1215 Chorro Street, San Luis Obispo.

A description of the technique of using multiple Kirschner wire pins, without incision, in obtaining positive fixation of the fragments with minimum risk. Report on end-results.

Discussion by Keene O. Haldeman, M.D., San Francisco.

Paper No. 89:

The Industrial Back from the Internist's Viewpoint: An Analytical and Statistical Study—Rutherford T. Johnstone, M.D., 423 Towne Avenue, Los Angeles.

No single entity in industrial medicine remains so ill-defined as the "disabling back." The orthopedist offers a diagnostic tableau which finds no unanimity of opinion. The general practitioner and industrial physician consistently stereotype all these cases with a diagnosis of "back strain or sacro-iliac strain." This proffered paper proposes to analyze three thousand cases examined from a standpoint of history, physical examination, x-ray studies, laboratory findings, reaction to treatment, length of treatment and temporary disability. The incidence of infection, disease of the adjacent organs, congenital anomalies, structural defects, neurologic aspects and trauma, is cited. Certain conclusions are suggested from the statistics.

Discussion by Frederic C. Bost, M.D., San Francisco.

Paper No. 90:

The Z Nail—Vernon P. Thompson, M.D., 2007 Wilshire Boulevard, Los Angeles.

The Z nail is specially adapted for the internal fixation of intracapsular femoral neck fractures. There is one universal length of such strength and shape as to control shear and rotation. Centimeter-spaced holes provide visual and x-ray calibration and self-retention by bone growth through them. Modified Z nails are adapted to the fixation of epicondylar, capitellar, malleolar and other fractures.

Discussion by Steele F. Stewart, M.D., Los Angeles.

Paper No. 91:

Depressed Skull Fractures—Mark Albert Glaser, M.D., and Frederick P. Shafer, M.D., 1118 Roosevelt Building, Los Angeles.

This will consist of a follow-up study of one hundred cases for a period of one to eight years with some original remarks as to the value of encephalography, case reports, dural repair based upon experimental studies, and post-traumatic epilepsy, as well as the handling of bony defects.

In addition, a follow-up study of the x-rays showing the status of the bone following grafts and fractures will be presented.

Discussion by E. J. Morrissey, M.D., San Francisco.

Second Meeting

Wednesday, May 3, 2:00 p. m.

Paper No. 92:

Errors in the Treatment of Fractured Carpal Scaphoid—Francis M. Findlay, M.D., Suite 1220 First National Bank Building, San Diego.

Fracture of the carpal scaphoid is a very common injury, frequently overlooked. Neglect in prompt recognition of this injury usually results in permanent disability because of secondary changes that occur in the bone. Immediate, adequate, and prolonged immobilization of the wrist usually results in complete recovery. The importance of repeated x-ray examinations and adequate immobilization are clearly stressed with lantern slides of illustrative cases.

Discussion by Richard McGoveny, M. D., Santa Barbara.

Paper No. 93:

Treatment of Interfascial Hematoma—Harold E. Crowe, M.D., 2417 South Hope Street, Los Angeles.

These lesions occur as the result of trauma. They are large collections of blood extravasated between the superficial fascia and deep fascia. It is a common practice in Europe and America to treat such hematomata by the application of heat. This treatment results commonly in gangrene, sloughing, and the formation of large secondarily infected ulcers which heal very slowly. The cause of this is explained. Treatment by pressure bandage is described. (With lantern slides.)

Discussion by Charles L. Lowman, M. D., Los Angeles.

Business Recess

Business meeting and election of officers.

Paper No. 94:

Factors to Be Considered in Bone Metabolism, with Suggestions as to Control—Charles F. Nelson, M.D., Suite 332, Beverly Professional Building, Beverly Hills.

The blood chemistry of several thousand patients reveals that 68 per cent show deficiencies in calcium, 35 per cent in phosphorus. Fresh fracture cases show 85 per cent low in calcium, 25 per cent low in phosphorus. Most patients with bone diseases, delayed union of fractures, have mineral imbalance. Observations of this study suggest: Mineral imbalance produces lowered resistance; demineralization probably precedes all bone diseases, including arthritis; predisposes to fractures and causes delayed union; soft callus can be mineralized in many instances without surgery; with optimal mineral balance, fractures will heal in syphilitic or diabetic patients; mineral imbalance should be established immediately in all fractures. A detailed management of several thousand cases of mineral imbalance has demonstrated that a ratio of three to one should be maintained with an optimal blood calcium of from 10 to 12 milligrams and an optimal blood phosphorus of from 3.5 to 4 milligrams. Other factors which influence bone metabolism will be discussed.

Discussion by Ward Rolland, M.D., Los Angeles.

Paper No. 95:

A Review of the End-Results in Fractures of the Os Calcis—Russell F. Jaekle, M.D., and Albert G. Clark, M.D., 450 Sutter Street, San Francisco.

Forty-four cases of acute fractures of the os calcis admitted to the Boulder City Hospital are presented. A simple classification of these fractures is offered from which a fairly accurate estimate of the end-results, in percentage of total permanent disability, can be made at the time of the first examination.

Discussion by Samuel S. Mathews, M. D., Los Angeles.

VIII

NEUROPSYCHIATRY SECTION

John B. Doyle, M.D., *Chairman*
1930 Wilshire Boulevard, Los Angeles

George S. Johnson, M.D., *Secretary*
Stanford University Hospital, San Francisco

First Meeting

Tuesday, May 2, 8:30 a. m.

Symposium on Alcoholism

This is a joint meeting with the General Medicine Section.

Already Listed as Paper No. 5.

The Importance of Individual Tolerance to Alcohol in the Evaluation of Chemical Tests of Drunkenness—Henry W. Newman, M.D., Stanford University School of Medicine, San Francisco.

The metabolism of alcohol proceeds at a constant rate, and is peculiarly resistant to change. It is thus possible to estimate, from one blood alcohol determination, the blood alcohol concentration at some previous time. The determination of alcohol in body fluids or in breath is simple and accurate. The weak point in the chemical diagnosis of drunkenness is due, however, to the fact that different individuals do not show the same degree of intoxication with the same blood alcohol concentration, due to inherent and acquired tolerance to alcohol. This tolerance has been shown to be a true tissue tolerance, and is not due to decreased absorption or increased elimination of alcohol.

Already Listed as Paper No. 6.

Psychiatric Treatment of Alcoholism—J. L. Henderson, M.D., Compton Sanitarium, Compton.

Alcoholism is widespread, has serious economic, social and medical aspects, and its treatment is probably second in human importance only to that of schizophrenia. Recently, literature points toward the family background of the alcoholic as being of major etiologic significance. This, it appears, has a profound influence upon the development of the individual's personality, and it is in this setting that alcoholism develops. Thus it is that we speak of an "alcoholic personality." Certain classifications can be applied to alcoholics, and this is of help principally in the matter of prognosis. The present commitment laws, discussed and compared with commitment laws of other states. Treatment of alcoholism in the state hospitals is reviewed. Approach to the problem through intensive psychotherapy is outlined and problems involved in individual treatment discussed. This approach has certain advantages and certain limitations. Its contributions to the solution of the problem of alcoholism are evaluated.

Already Listed as Paper No. 7.

Subacute Alcoholic Cirrhosis of the Liver: A Clinical and Pathologic Study of Eighty Cases—Ernest M. Hall, M.D., University of Southern California School of Medicine, Los Angeles; W. A. Morgan, M. D., Los Angeles County Hospital, Los Angeles.

A study of some eighty cases of cirrhosis in the early phase in which the liver is enlarged and often fatty, showing a subacute proliferative inflammation. Such livers selected on anatomic grounds were associated with chronic alcoholism in 80 per cent of the patients.

Already Listed as Paper No. 8.

The Use of Vitamins in the Treatment of Alcoholic Disorders—John M. Askey, M.D., 902 Wilshire Medical Building, Los Angeles.

A review of the recent developments in the recognition of the rôle of vitamin deficiencies in the etiology of alcoholic disorders; with a discussion of the present trend in therapy.

Discussion by Paul J. Hanzlik, M.D., San Francisco; Percy Poliak, M.D., San Francisco; John M. Nagle, M.D., Agnew; Newton Evans, M.D., Los Angeles; Charles L. Connor, M.D., San Francisco; George H. Houck, M.D., Los Angeles.

Already Listed as Paper No. 9.*

Clinical-Pathological Conference—Conducted by Chester S. Keefer, M.D., Associate Professor of Medicine, Harvard Medical School, Boston; William Dock, M. D., Professor of Pathology, Stanford Medical School, San Francisco; and Jesse Carr, M.D., University of California Hospital, San Francisco.

Note.—Protocols of the cases under discussion, with complete clinical histories and laboratory findings, will

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Section Aides: R. B. Raney, M.D., Los Angeles; William T. Grant, M.D., Los Angeles.

* This Clinical-Pathologic Conference will be a General Meeting, commencing at 11:15 a.m. Presiding, President William W. Roblee, M. D.; Director, William H. Barrow, M. D. See special notice under General Meetings.

be distributed. These case histories will be discussed by the guest speaker and differential diagnoses presented, following which the pathological findings will be presented and discussed.

The three cases may be summarized briefly as follows:

1. Febrile illness of two years' duration; appendectomy and nephropexy without relief of abdominal pain.
2. Severe hypertension noted after pneumonia in a man whose pressure was normal a few months before. Postoperative complications following splanchnic nerve resection.
3. Twenty-five years of "peptic ulcer" history followed by appearance of abdominal masses, cough, and hemoptysis.

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Second Meeting

Wednesday, May 3, 1:30 p. m.

Paper No. 96:

Chairman's Address: Santiago Ramón y Cajal—John B. Doyle, M.D., 1930 Wilshire Boulevard, Los Angeles.

The life of Cajal is reviewed briefly. Emphasis is laid upon the characteristics of the man as well as his contributions to the field of neurology.

Paper No. 97:

Quantitative Methods in the Diagnosis of Brain Tumors—William T. Grant, M.D., 1136 West Sixth Street, Los Angeles.

The measuring and graphic recording of neurological responses constitute a great advance in the earlier recognition and localization of brain tumors. Instead of reporting that the sense of smell is diminished on one side we may now employ the technique of Elsberg and say that the minimum identifiable odor is so many cubic centimeters by blast injection. Such quantitative methods have been devised for many parts of the neurological examination, allowing absolute values to be determined. They enable comparisons to be made among different patients, and also in the same patient from time to time. It is proposed to review briefly the various methods and to comment on their application.

Discussion by Frederick L. Reichert, M. D., San Francisco.

Business Recess

Business meeting and election of officers.

Paper No. 98:

Anancastic Depressions: Obsessive-Compulsive Symptoms Occurring During Depressions—Ernest G. Lion, M.D., 490 Post Street, San Francisco.

Clinical observations made on patients at Stanford University Hospitals and the Psychiatric Clinic of Yale University School of Medicine, who exhibited obsessive-compulsive symptoms occurring predominantly during the course of a depression, form the basis of this paper. Illustrative cases are presented. The characteristics of the mental status and the physiologic concomitants are discussed. The rigid, anancastic prepsychotic personality which was found, and its influence on the course of the illness, are considered. The diagnostic problems involved are mentioned. The way of experiencing is differentiated from the experiential content. Emphasis is placed upon the need of judicious therapeutic management of these patients.

Discussion by Sydney K. Smith, M.D., Oakland.

Paper No. 99:

Mongolism: A Study of Two Hundred and Sixty Institutional Cases, with Special Emphasis on Congenital Heart Conditions—Robert E. Wyers, M.D., Pacific Colony, Spadra; Kate Brousseau, Ph.D., Los Angeles, and Robert W. Langley, M.D., 1930 Wilshire Boulevard, Los Angeles.

Various theories on Mongolism were reviewed and a study made of all such cases in Sonoma State Home and Pacific Colony to compare our findings with those reported previously. This study deals with etiology, incidence, and anomalies—under anomalies special emphasis being put upon congenital heart lesion.

Discussion by F. O. Butler, M.D., Sonoma.

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IX

PATHOLOGY AND BACTERIOLOGY SECTION

Alvin G. Foord, M.D., *Chairman*
Huntington Memorial Hospital, Pasadena
Roy W. Hammack, M.D., *Secretary*
657 South Westlake Avenue, Los Angeles
Paul H. Guttman, M.D., *Assistant Secretary*
1127 Eleventh Street, Sacramento

First Meeting

Monday, May 1, 1:30 p. m.

Paper No. 100:

Chairman's Address: Thrombosis of Mesenteric Vein—Alvin G. Foord, M.D., Huntington Memorial Hospital, Pasadena.

So-called spontaneous thrombosis of the superior mesenteric vein is a rare acute abdominal lesion. A review of recent literature as to its frequency, clinical symptoms, and discussion of etiology, pathogenesis, and pathologic results will be given. A report of an autopsied case without clinically demonstrable antecedent abdominal disease, is reported.

Paper No. 101:

Traumatic Hemorrhages of the Brain Stem—A. M. Moody, M.D., St. Francis Hospital, San Francisco, and Jesse Carr, M.D., University of California Hospital, San Francisco.

Over a period of ten years, a series of cases has been collected at the San Francisco Coroner's office and elsewhere, in which trauma, delivered externally to the face and head, had caused hemorrhages in the medulla and pons Varolii. The mechanism of production of this type of brain lesion, the clinical and pathological sequences, and the histopathology at autopsy will be discussed.

Paper No. 102:

Causes of the Occasional Failure of the Subcutaneous Inoculation of Guinea Pigs for the Demonstration of Tubercle Bacilli when Present in Very Small Numbers—J. E. Pottenger, M.D., Pottenger Sanatorium and Clinic, Monrovia.

Resistance to infection of individual animals; the expulsion of the inoculum due to early nontuberculous abscess formation and ulceration; excess of inert matter in inoculum preventing the bacilli from coming in contact with the tissues of the animal.

Paper No. 103:

Mushroom Poisoning — Frederick Proescher, M.D., Santa Clara County Hospital, San Jose.

Report of six cases of mushroom poisoning caused by Amanita virosa. Clinical course and autopsy find-

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Section Aides: Paul Guttman, M.D., Sacramento; Paul Michael, M.D., Oakland; Albert F. Brown, M.D., Los Angeles; Elmer W. Smith, M.D., San Francisco.

ings in two fatal cases will be discussed. Review of present knowledge of chemical nature of the Amanita poisons. Brief outline for treatment of mushroom poisoning.

Paper No. 104:

Arteriosclerotic Aneurysms of the Aorta and Major Arteries: A Clinico-Pathological Study—Clark E. Brown, M.D., 2411 Anacapa Street, Santa Barbara.

Nine arteriosclerotic aneurysms, eight of which are from postmortem and one from surgical material are reported. Aneurysms of the thoracic and abdominal aorta, hypogastric, renal, gluteal, popliteal and basilar arteries are considered. These are discussed from the standpoint of age, duration, symptoms, roentgenologic findings and gross pathological and microscopical appearance.

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Second Meeting

Tuesday, May 2, 8:30 a. m.

Paper No. 105:

Latent Choriocarcinoma—Albert F. Brown, M.D.; Wilfred Snodgrass, M.D., and Orlyn B. Pratt, M.D., 312 North Boyle Avenue, Los Angeles.

Occurrence of pulmonary choriocarcinoma eight years after a molar pregnancy, demonstrates the ability of deported chorion to undergo delayed malignant development.

Complete hysterectomy, six years before the appearance of the choriocarcinoma, provides unusual proof of a genuine period of latency in this type of tumor.

Paper No. 106:

Bone Marrow Studies as a Diagnostic Aid in Early Leukemia—Ernest H. Falconer, M.D., 384 Post Street, San Francisco.

Paper presents clinical data of patients with actual or suspected blood dyscrasias. Aspirated sternal marrow studies are correlated with these clinical findings and laboratory studies in an attempt to rule in or out the diagnosis of leukemia. To evaluate sternal marrow biopsy as an aid to the early diagnosis of leukemia, is in particular, sought.

Business Recess

Business meeting and election of officers.

Paper No. 107:

On the Value of the Complement Fixation Test in the Diagnosis of Psittacosis—K. F. Meyer, M.D. (by invitation), George Williams Hooper Foundation for Medical Research, University of California, San Francisco.

Using boiled Maitland cultures of the particulate psittacosis virus or spleens of infected mice, as antigens is a very scientific complement-fixation system. Typical and abortive human infections have been diagnosed early in the course of the illness. The progressive rise of antibodies in the serum of a very severe laboratory infection in the light of these observations and the mechanism of immunity, will be discussed.

Paper No. 108:

Experimental Pathology Related to the Female Sex Hormones: a Review—Isabella H. Perry, M.D., Division of Pathology, University of California, San Francisco.

Since the isolation of the female sex hormone a decade ago a large and diverse literature has accumulated on lesions produced experimentally with it. These range from congenital sexual malformations to involutional hyperplasias, and include the endocrine, sex, skeletal, hematopoetic vascular, and nerve systems.

Paper No. 109:

Metastasis of Carcinoma to the Spleen—Paul H. Guttman, M.D., 605 Medico-Dental Building, Sacramento.

A review is given of the literature on the frequency of metastasis of carcinoma to the spleen. The anatomic factors controlling metastasis are also considered. A case is reported of carcinoma of the lung with extensive metastasis to the spleen.

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X

PEDIATRICS SECTION

Harold K. Faber, M.D., *Chairman*
Stanford Hospital, San Francisco
Hartzell H. Ray, M.D., *Secretary*
23 Second Avenue, San Mateo
W. W. Belford, M.D., *Assistant Secretary*
Medico-Dental Building, San Diego

First Meeting

Monday, May 1, 1:30 p. m.

Paper No. 110:

Tubercle Bacilli in the Gastric Contents of Tuberculous Children—Samuel Hurwitz, M.D., 490 Post Street, San Francisco; E. Rosencrantz, M.D., University of California School of Medicine, San Francisco.

The gastric contents of 164 tuberculous children were inoculated into guinea pigs and the results were analyzed in relation to contact history, clinical findings, x-ray and pathological findings of the tonsils. Positive gastric washings were obtained in approximately 50 per cent of the group as a whole, in all cases under one year of age, and in 100 per cent of those with pathological tuberculous tonsils.

Discussion by Ernest Wolff, M.D., San Francisco; Lloyd Dickey, M.D., San Francisco.

Paper No. 111:

The Present Status of Pertussis Immunization—John J. Miller, M.D., 2000 Van Ness Avenue, San Francisco.

The evidence for and against different Phase I H. pertussis vaccines will be summarized. The literature as it pertains to immunization will be reviewed and summarized. An attempt will be made to analyze critically the material and make recommendations for the use of certain products.

Discussion by William C. Deamer, M.D., San Francisco.

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Second Meeting

Wednesday, May 3, 8:30 a. m.

Business Recess

Business meeting and election of officers.

Paper No. 112:

Effective Sulfanilamid Dosage: The Value of Quantitative Blood Studies—William J. Mitchell, M.D., 1200 State Street, Los Angeles; Paul M. Hamilton, M.D., 284 East Main Street, Alhambra; and Albert G. Bower, M.D., 136 North Central, Glendale.

Most of the work done on sulfanilamid has dealt with its therapeutic properties from the qualitative

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Section Aides: Ralph Netzley, M.D., Pasadena; John Rector, M.D., San Francisco; A. Lawrence Gleason, M.D., Oakland; Harry R. Lusignan, M. D., Monterey.

standpoint. Dosage has been accepted on an arbitrary ratio to body weight. Such an arbitrary dosage may produce an entirely inadequate blood concentration due to individual variations in absorption and excretion. Further, different diseases respond to different blood concentrations.

Discussion by Andrew B. Stockton, M.D., San Francisco.

Paper No. 113:

Erythema Infectiosum: With a Report of an Epidemic in San Francisco—Sidney N. Zuckerman, M.D., 490 Post Street, San Francisco.

This paper will include an introduction, the synonyms of erythema infectiosum, and a complete historical background of the disease. Following this will be a description of the disease picture based on a comparison of previously reported signs and symptoms with those observed in the San Francisco epidemic.* A report of 128 cases of erythema infectiosum occurring in San Francisco in the summer of 1938 will be given.

Discussion by K. F. Meyer, M.D., San Francisco; E. B. Shaw, M.D., San Francisco; E. A. Wayburn, M.D., San Francisco; Garnet Cheney, M.D., San Francisco.

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Third Meeting

Wednesday, May 3, 1:30 p. m.

Symposium on Poliomyelitis

This is a joint meeting with the General Medicine Section.

Already Listed as Paper No. 14.

The Basic Nature of Poliomyelitic Infection—Harold K. Faber, M.D., Stanford University School of Medicine, San Francisco.

In this paper will be discussed the virus of poliomyelitis, its tissue affinities, its mode of entrance into the body, the lesions it causes and the bearing which these features have on symptomatology, diagnosis, prevention, and treatment.

Already Listed as Paper No. 15.

Some Basic Contributions of Experimental Poliomyelitis to Our Knowledge of the Human Problem—E. W. Schultz, M.D., Stanford University School of Medicine, San Francisco.

A summary of the fundamental aspects of poliomyelitis as gathered from studies of the experimental disease, with special reference to its pathogenesis and the problems it presents from the standpoint of the treatment and the prevention of the acute disease.

Already Listed as Paper No. 16.

Symptomatology and Differential Diagnosis in Poliomyelitis—Albert G. Bower, M.D., Clinical Professor of Medicine, University of Southern California Medical School, Los Angeles.

The criteria for the recognition of the preparalytic (abortive) case of poliomyelitis and the evaluation of the spinal fluid findings. Consideration of the carrier problem. A discussion of the relationship of the pathology and spinal fluid findings.

Already Listed as Paper No. 17.

The Treatment of Poliomyelitis—Edward B. Shaw, M.D., 384 Post Street, San Francisco.

Our practical knowledge of the treatment of this disease is mostly concerned with the support of damaged muscles, the prevention of contractures, the maintenance of respiration and other vital functions, the maintenance of complete bodily rest, and measures to facilitate the restoration of function.

Serum treatment is a matter of great theoretical interest; it is our only approach, whether effective or not, to specific therapy.

Note.—At the conclusion of the symposium a motion picture film on poliomyelitis will be shown. This film has been prepared by Albert G. Bower, M.D., of Los Angeles, and shows methods of diagnosing in the admitting room; hospital treatment after the diagnosis is completed, including the respirator and respirator room; postquarantine orthopedic hospital warm pool, and physical therapy treatments.

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XI

RADIOLOGY SECTION

Karl M. Bonoff, M.D., *Chairman*
1930 Wilshire Boulevard, Los Angeles
Carl D. Benninghoven, M.D., *Secretary*
Mills Memorial Hospital, San Mateo

First Meeting

Monday, May 1, 1:30 p. m.

Paper No. 114:

The Clinical Aspect of Electrically Produced Gamma Rays—Albert Soiland, M.D., 1407 South Hope Street, Los Angeles.

Outside of radium, radioactive elements or salts, rays of ultra short wave length are obtained from any vacuum tube energized by high voltage. When this voltage reaches 500 kv., ultra short wave length radiation is in the ascendency, and after 2,000 kv. the emission is practically of the pure gamma type. Clinical experience with the higher voltages is commented upon in this report.

Discussion by John Lawrence, M.D., San Francisco; Frederick Rodenbaugh, M.D., San Francisco.

Paper No. 115:

The Treatment of Carcinoma of the Pharynx and Larynx—L. Henry Garland, M.D., 450 Sutter Street, San Francisco.

The majority of malignant tumors of the pharynx and larynx are already inoperable when presented for treatment. For those that are operable, it is to be emphasized that complete and total excision is the most certain method of cure. However, for the great majority of cases, which are unfortunately inoperable, the most efficient weapon which we have at our disposal today is roentgen irradiation. The present paper is a discussion of our method of roentgen therapy of these neoplasms, and of the results obtained, including a report of five years' survivals in cases both of laryngeal and pharyngeal cancer treated exclusively by roentgen irradiation.

Discussion by Robert E. Stone, M.D., San Francisco; Otto H. Pfleuger, M.D., San Francisco.

Paper No. 116:

Symmetrical Parietal Dysplasia—Robert A. Powers, M.D., 261 Hamilton Avenue, Palo Alto.

Symmetrical thinness of the skull has been described as senile atrophy, an atrophy not necessarily senile, as a congenital defect, as a result of muscular action, and even as of traumatic origin. Few reports in the roentgen literature have dealt with this unusual and striking condition. Report of a case discovered during routine examination.

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* Permission to use the case reports was obtained through the courtesy of the San Francisco Department of Public Health.

Section Aides: Charles A. Galligan, Jr., M.D., Monterey; Arthur J. Williams, M.D., San Francisco; Wilbur Bailey, M.D., Los Angeles; Elmer N. Liljedahl, M.D., Los Angeles.

Discussion by C. S. Capp, M.D., San Francisco; E. E. Leef, M.D., San Francisco.

Paper No. 117:

Internal Cranial Hyperostosis: Its Clinical Significance—B. N. Tager, M.D., E. Kost Shelton, M.D., 921 Westwood Boulevard, Los Angeles; W. C. Matzen, M.D., 921 Westwood Boulevard, Los Angeles.

The general incidence, sex, and age distribution of internal cranial hyperostosis is established, and correlated with clinical and biochemical findings. Theories of etiology of this condition are briefly discussed.

Paper No. 118:

An Unusual Case of Dwarfism: Resulting from Roentgen Radiation of Pregnant Mother?—S. J. Glass, M.D., 1930 Wilshire Boulevard, Los Angeles.

A microcephalic dwarf, age eleven years, with failure of somatopsychic development. Was born after mother was subjected to weekly destructive roentgen radiation over pelvis during last six months of pregnancy in attempt to induce abortion.

Discussion by Benjamin Tager, M.D., Los Angeles; Clyde Emery, M.D., Los Angeles.

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Second Meeting

Tuesday, May 2, 11:15 a. m.

GENERAL ASSEMBLY

Paper No. 119:

Some Indications for the Use of Roentgen-Ray Treatment—U. V. Portmann, M.D., Cleveland Clinic, Cleveland, Ohio. (By invitation.)

The newer developments in the treatment of inflammatory and endocrine disturbances will be discussed, as well as the treatment of carcinoma and the results to be expected from radiation.

Recess

PACIFIC ROENTGEN CLUB CONFERENCE

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Third Meeting

Wednesday, May 3, 8:30 a. m.

SYMPOSIUM ON CARCINOMA OF THE BREAST

This is a joint meeting with the Surgical Section.

Already Listed as Paper No. 29.

The Spread of Breast Cancer—Eric Liljencrantz, M.D., Stanford University Hospital, San Francisco.

Distribution of metastases in a thousand patients dying with carcinoma has been studied. Breast carcinoma has been found to spread more widely than any other epithelial tumor. Its paths of metastases have been traced, representative material collected. This is presented to illustrate problems which must be faced in clinical management.

Already Listed as Paper No. 30.

Borderline Intraductal Hyperplasias of the Breast—Alson R. Kilgore, M.D., 490 Post Street, San Francisco.

Overgrowths within ducts cause rise to persistent disagreement among pathologists. Probably most examples are benign and remain so, but some are certainly precancerous. Diagnostic significance of nipple erosion and discharges. Illustrative cases.

Discussion by Robert E. Stone, M.D., San Francisco; Lyell C. Kinney, M.D., San Diego.

Already Listed as Paper No. 31.

Surgical Treatment of Carcinoma of the Breast—Stuart W. Harrington, M.D., Mayo Clinic, Rochester, Minn.

Recognition of malignant disease of the breast by clinical signs and symptoms depends on the duration of the lesion at the time of examination; these signs and symptoms are hopelessly inadequate in determining early malignant disease.

There are many factors which influence prognosis, the most important of which are the type of malignant disease which is present, the degree of malignancy as shown by the microscopic examination of the tissue, the age of the patient, the presence of other conditions such as diabetes, exophthalmic goiter, etc., the extent of the disease at the time of operation, and the thoroughness with which the radical operation is done. The following studies and results of operation are based on a series of 5,105 cases in which the patients were operated on in the period of 1910–1935, inclusive.

Surgical discussion for this program by H. Glenn Bell, M.D., San Francisco; Verne C. Hunt, M.D., Los Angeles.

Already Listed as Paper No. 32.

Treatment of Carcinoma of the Breast from the Standpoint of the Radiologist.—U. V. Portmann, M.D., Cleveland Clinic, Cleveland, Ohio. (By invitation.)

Discussion by Robert E. Stone, M.D., San Francisco; Lyell C. Kinney, M.D., San Diego.

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Fourth Meeting

Wednesday, May 3, 1:30 to 4:00 p. m.

Paper No. 120:

Roentgenological Study of the Fractured Clavicle—R. S. Graham, M.D., 1830 L Street, Sacramento.

For more than two years the author has used an oblique view in addition to the usual postero-anterior projection to demonstrate the relationship of fragments in clavicle fractures. The advantages of biplane examination are discussed and demonstrated by slides, and the technical problem considered.

Paper No. 121:

Differential Diagnosis of Intestinal Obstruction by Means of X-ray Examination—Joseph Levitin, M.D., 516 Sutter Street, San Francisco.

Properly performed x-ray examination can often differentiate a mechanical obstruction, paralytic ileus, and peritonitis. A study is made of the abdomen by films, in two or more planes, and attention paid to the character of the loops of distended bowel, size and mobility.

Discussion by Clayton Lyons, M.D., San Francisco.

Paper No. 122:

Liver or Gall-Bladder Disease? A Simultaneous Functional Test for Each, with a Critical Evaluation—Charles S. Capp, M.D., University of California Hospital, San Francisco.

A group of hospitalized patients presenting major symptoms or signs of liver or gall-bladder dysfunction has been studied intensively. Every case had a simultaneous testing of liver excretory function coupled with cholecystographic functional tests. The completed hospital records have been critically reviewed, and a correlation attempted from the accumulated clinical findings, from the roentgen examinations, the clinical laboratory data, from the surgical and pathologic findings, and from a limited number of postmortem examinations.

Discussion by F. S. Foote, M.D., San Francisco; S. P. Lucia, M.D., San Francisco.

Paper No. 123:

Chairman's Address: Water Absorption from the Colon and Its Relation to Motility—Karl M. Bonoff, M.D., 1930 Wilshire Boulevard, Los Angeles.

Business Recess

Business meeting and election of officers.

PACIFIC ROENTGEN CLUB CONFERENCE

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XII

UROLOGY SECTION

CARL RUSCHE, M.D., *Chairman*
905 Taft Building, 1680 North Vine Street, Hollywood
JOHN A. DOUGHERTY, M.D., *Secretary*
3115 Webster Street, Oakland

First Meeting

Monday, May 1, 8:30 a. m.

Paper No. 124:

The Survey of a Series of Urologic Patients—Leon I. Oppenheimer, M.D., Dalziel Building, Oakland.

The survey of one thousand patients referred to the Urologic Department, Oakland Health Center, over a five-year period. A discussion of these conditions as they occurred in the men and women is undertaken with comparison as to relative frequency and character. The importance of maintaining an anatomic index is emphasized.

Discussion by James R. Dillon, M.D., San Francisco; A. J. Scholl, M.D., Los Angeles.

Paper No. 125:

Four Years' Experience with an Operation for the Relief of Impotence—Oswald S. Lowsley, M.D., 899 Park Avenue, New York City; Robert W. Hunt, M.D., 899 Park Avenue, New York City; and James L. Bray, M.D., 727 West Seventh Street, Los Angeles.

Technique of operation and results on selected cases over a period of four years. The type of impotence applicable to this procedure and also the contraindications are discussed. Chart of the operative cases and lantern slides of the operation will be presented.

Discussion by Nathan G. Hale, M.D., Sacramento; Lloyd Reynolds, M.D., San Francisco.

Paper No. 126:

Papilloma of the Kidney Pelvis—William W. Cross, M.D., 1624 Franklin Street, Oakland.

Case report: Nephrectomy four years ago for papilloma of renal pelvis. Recently the patient returned with a recurrence in the ureter of the same side. Lantern slide demonstration, some of which are colored.

Discussion by William E. Stevens, M.D., San Francisco; Paul Michael, M.D., Oakland. (By invitation.)

Paper No. 127:

Preoperative Estimation of the Risk in Urologic Surgery—James C. Negley, M.D., 229 North Central Avenue, Glendale.

Considers blood chemistry, kidney function, phthalein, electrocardiograms, type of operation, pathology present, number of patients on urology wards (10,522), number of blood chemistry examinations (8,341), number of patients (547) with abnormal blood chemistry, surgery done in this group of patients, and mortality rate.

Discussion by Albert M. Meads, M.D., Oakland; Dudley P. Fagerstrom, M.D., San Jose.

Paper No. 128:

Chairman's Address: Vesico-Intestinal Fistula (with report of four cases, namely, operative trauma complicated by carcinoma of the ovary, carcinoma of the sigmoid, gun-shot wound, and diverticulitis).—Carl Rusche, M.D., 906 Taft Building, Hollywood.

The paper consists of a discussion of the etiology, diagnosis, and treatment of vesico-intestinal fistula. Included are the reports of four interesting cases which demonstrate the common causes of the condition.

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Second Meeting

Tuesday, May 2, 2:30 to 5:00 p. m.

Paper No. 129:

Is Cystoscopy Necessary in the Larger Prostatic Hypertrophies?—B. M. Palmer, M.D., Franklin Building, Oakland.

Section Aides: Thomas I. Buckley, M.D., Oakland; B. M. Palmer, M.D., Oakland.

Most picturesque of Del Monte's golf courses is the exclusive Cypress Point links.

The beautiful seventh hole on the Pebble Beach golf course.

Using lantern slides, we will present information obtained from a study of one hundred air cystograms and sodium iodid cystograms taken on patients having prostatic hypertrophy. We believe cystoscopy unnecessary in the larger prostatic hypertrophies.

Discussion by Nathaniel G. Alcock, M.D., Iowa City, Iowa. (by invitation); George W. Hartman, M.D., San Francisco; Curtis H. McDonnell, Sacramento.

Business Recess

Business meeting and election of officers.

Paper No. 130:

Treatment of Gonorrhea by Artificial Fever and by Fever Therapy in Combination with Sulfanilamid—Elmer Belt, M.D., 1893 Wilshire Boulevard, Los Angeles, and Alvin W. Folkenberg, M.D., 1893 Wilshire Boulevard, Los Angeles.

A résumé of cases treated: (1) with a single ten-hour fever at 106.7 degrees rectal temperature, (2) with sulfanilamid combined with multiple short fevers of 103 to 106 degrees, and (3) with a single fever equal to the thermal death time of the patient's own strain of gonococcus.

Discussion by F. B. Moor, M.D., Los Angeles; Rodney F. Atsatt, M.D., Santa Barbara; Gerald O'Hara, M.D., San Francisco. (By invitation.)

Paper No. 131:

Ureterostomy for Carcinoma of the Cervix—Lional P. Player, M.D., 384 Post Street, San Francisco.

Curettement without histological study several weeks previously. Patient referred because of hematuria. Cystoscopy revealed a submucosal neoplasm and bleeding from the left ureteral orifice. Rectovesical palpation gave one the impression that the tumor involved the rectal wall, uterus and bladder.

Discussion by Charles P. Mathe, M.D., San Francisco; Robert V. Day, M.D., Los Angeles.

Paper No. 132:

Ureteral Kinks and Strictures—H. C. Bumpus, Jr., M.D., 112 North Madison Avenue, Pasadena.

Paper consists of a discussion of ureterograms, with special reference to the interpretation of changes resulting from both intra and extra ureteral pathology. Included is the report of a case of ureteral intussusception and the demonstration of apparent strictures in fully dilated ureters.

Discussion by Thomas E. Gibson, M.D., San Francisco; James A. May, M.D., San Diego.

Paper No. 133:

Lymphogranuloma Venereum — The Fourth Venereal Disease—Pathology and New Treatment—Report of Twenty-five Cases—Abstract of Sixty Cases Treated at Panama, Canal Zone—Francis H. Redewill, M.D., Flood Building, San Francisco, and Captain C. F. Lyter, Medical Corps, U.S.A., Presidio of San Francisco. (By invitation.)

Pathology: (*a*) Inguinal type; (*b*) cases with anorectal syndrome. Treatment: Medical, surgical. Discussion of various preparations: Tartar emetic, stibyal, faudin, anthiomalin, sulfanilamid.

Anthiomalin (lithium antimoniothiomalate) effective in 50 per cent of cases. Dosage and method of administration. Signs and symptoms of saturation. Treatment with sulfanilamid more promising. Report of cases and comparison of treatment using various antimony drugs and sulfanilamid. Conclusions. (Lantern slides.)

Discussion by Miley B. Wesson, M.D., San Francisco.

The main lounge, Hotel Del Monte.

The dining room, Hotel Del Monte.

III—HOUSE OF DELEGATES MEETINGS

36th ANNUAL SESSION—AUDITORIUM, HOTEL DEL MONTE

Speaker, LOWELL S. GOIN, Los Angeles *Vice-Speaker*, JOHN H. GRAVES, San Francisco
Secretary, GEORGE H. KRESS, San Francisco

FIRST MEETING

Monday, May 1, 8 p. m.

Order of Business

1. Call to order.
2. Report of Committee on Credentials.
3. Roll call.
4. Announcement and approval of Reference Committees.*
   - (*a*) Committee on Credentials.
   - (*b*) Reference Committee on the Reports of Officers and Standing Committees.
   - (*c*) Reference Committee on the Report of the Council and the Report of the Secretary-Treasurer.
   - (*d*) Reference Committee on Resolutions, Amendments to the Constitution and By-Laws, and New and Miscellaneous Business.
5. President's address—William W. Roblee.

   Reports: †
6. Annual report of the Council—Karl L. Schaupp, Chairman.
7. Report of the Trustees Of The California Medical Association—Karl L. Schaupp, President.
8. Report of Auditing Committee—T. Henshaw Kelly, Chairman.
9. Report of Secretary-Treasurer—George H. Kress.
10. Report of Editor—George H. Kress.
11. Report of General Counsel—Hartley F. Peart.
12. Report of Committee on Public Relations—George G. Reinle.
13. Reports of Standing and Special Committees:
    - A. Standing Committees.
      - Executive Committee—T. Henshaw Kelly.
      - Committee on Associated Societies and Technical Groups—John V. Barrow.
      - Committee on Health and Public Instruction—Fred B. Clarke.
      - Committee on History and Obituaries—Frank R. Makinson.
      - Committee on Hospitals, Dispensaries and Clinics—W. Earl Mitchell.
      - Committee on Industrial Practice—Philip Stephens.
      - Committee on Medical Defense—George G. Reinle.
      - Committee on Medical Economics—John H. Graves.
      - Committee on Medical Education and Medical Institutions—Loren R. Chandler.
      - Committee on Membership and Organization—George D. Maner.
      - Committee on Postgraduate Activities—John C. Ruddock.
      - Committee on Publications—Ralph Eusden.
      - Committee on Public Policy and Legislation—Junius B. Harris.
      - Committee on Scientific Work—George H. Kress.
      - Committee on Public Relations—George G. Reinle.
      - Cancer Commission—Alson R. Kilgore.
    - B. Special Committees.
      - Committee on Medical Research—Philip K. Gilman.
      - Committee on Syphilis—Howard Morrow.
      - Committee on Cancer Exhibit, Golden Gate International Exposition—T. Henshaw Kelly.
      - Committee on County Hospitals—Louis A. Packard.
      - Committee on a Basic Science Law—George H. Kress.
14. Unfinished Business.

    No unfinished business.
15. Resolutions and New Business.

    (NOTE: *All resolutions must be presented in writing and be in triplicate.*)
16. Approval of Minutes.
17. Recess to Wednesday, 8 p. m.

SECOND MEETING

Wednesday, May 3, 8:00 p. m.

Order of Business

1. Call to order.
2. Supplemental Report of Credentials Committee.
3. Roll call.
4. Secretary's announcement of Council's selection of place for the 1940 annual session.
5. Elections:
   - (*a*) President-Elect.
   - (*b*) Speaker.
   - (*c*) Vice-Speaker.
   - (*d*) Councilors:
     - Second District—Carl R. Howson, Los Angeles (term expiring).
     - Fifth District—Alfred L. Phillips, Santa Cruz (term expiring).
     - Eighth District—Frederick N. Scatena, Sacramento (term expiring).
   - (*e*) Councilors-at-Large:
     - C. O. Tanner, San Diego (term expiring).
     - T. Henshaw Kelly, San Francisco (term expiring).
   - (*f*) Delegates to the American Medical Association—Incumbents:
     - Elbridge Best, San Francisco (term expiring).
     - Lyell C. Kinney, San Diego (term expiring).
     - J. P. Nuttall, Santa Monica (term expiring).
   - (*g*) Alternates to the American Medical Association—Incumbents:
     - Robert S. Stone, San Francisco (term expiring).
     - Bon O. Adams, Riverside (term expiring).
     - F. M. Pottenger, Los Angeles (term expiring).
6. Announcement and Approval of Members of Standing Committees Elected by the Council.
7. Report of Reference Committees:
   - (*a*) Reports of Council and Secretary-Treasurer.
   - (*b*) Reports of Officers, Standing and Special Committees.
   - (*c*) Resolutions, Amendments, New and Miscellaneous Business.
8. Unfinished Business.
9. Presentation of Officers:
   - President.
   - President-Elect.
   - Speaker.
   - Vice-Speaker.
10. Presentation of President's Certificate to William W. Roblee.
11. Approval of Minutes.
12. Adjournment.

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* Excerpt from the California Medical Association By-Laws: Chapter III, Section 6, Paragraphs (a) and (b).

Section 6 (a). Appointment of Committee on Credentials and three Reference Committees.

Prior to or at the beginning of an annual session, the Speaker of the House shall appoint from the members thereof the following committees:

1. Committee on Credentials.
2. Reference Committee on the Reports of Officers and Standing Committees.
3. Reference Committee on the Report of the Council and the Report of the Secretary-Treasurer.
4. Reference Committee on Resolutions, Amendments to the Constitution and By-Laws, and New and Miscellaneous Business.

(b) Membership of Credentials and Reference Committees.

Each of the aforesaid committees shall consist of three members, the chairman of each to be designated by the Speaker.

The Speaker, the House concurring, shall refer said reports, resolutions, and business to the respective Reference Committees, but may allocate among them any of said reports, resolutions or portions thereof, and other business, to avoid duplication and to expedite the business of the House of Delegates.

The Reference Committees shall present written reports dealing with and making recommendations on all matters submitted to them. The report of each committee shall be read by its chairman first as a whole, and the House of Delegates shall then act and vote upon the report as a whole or section by section, as it may deem best.

† Reports of officers, standing and special committees appear in full text in the Pre-Convention Bulletin, printed as an appendix to this annual session program.

IV—OTHER MEETINGS

I

CANCER COMMISSION PATHOLOGY CONFERENCE

Sunday, April 30, 9:30 a. m. to 12 noon, and 1:30 to 4:30 p. m.

Hotel Del Monte, Del Monte

The usual semi-annual Microscopic Conference of the Cancer Commission of the California Medical Association will be held at the Hotel Del Monte on Sunday, April 30, 1939, at 9: 30 a. m. This meeting will be conducted in the same manner as in the past; case histories being presented and slides passed out for diagnosis by each attendant. A very interesting group of cases has been assembled, and it will be necessary for each attendant to bring his own microscope.

The meeting will consist of morning and afternoon sessions, and will be conducted by the following committee: Dr. Paul Michael (chairman), Dr. Jesse Carr, and Dr. Alvin Cox.

Please make reservations with the chairman of the committee at 434 Thirtieth Avenue, Oakland; or with Dr. Otto H. Pflueger, Secretary of the Cancer Commission, 384 Post Street, San Francisco.

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II

PROGRAM FOR GENERAL MEETING

Sunday, April 30, 10 a. m. to 12 noon, and 2 to 4 p. m.

10 : 00 a. m.—*Skin Cancers.*
  Clinical Aspects—Otto Pflueger.
  Pathological Aspects—Jesse Carr.
  Radiological Treatment—Henry Ullmann.
11 : 00. a. m.—*Pigmented Lesions of the Skin.*
  Clinical Aspects—Nelson Howard.
  Pathological Aspects—David Wood.
2–4 p. m.—*Breast Tumors.*
  Benign Tumors—Newton Evans.
  Malignant Tumors—Ernest Hall.
    Clinical Aspects—Clarence Berne.
    Radiological Aspects—William Costolow.

Reservations should be made with the secretary of the Cancer Commission, Otto H. Pflueger, M.D., 384 Post Street, San Francisco.

Each attendant should bring his own microscope for the study of prepared slides of the cases presented.

III

CANCER COMMISSION RADIOLOGY CONFERENCE

Sunday, April 30, 10 a. m. to 3:30 p. m.

Hotel Del Monte, Del Monte

The Cancer Commission is again sponsoring a Radiological Conference on Sunday, April 30, at Del Monte. The meetings will be held in one of the rooms of the Hotel Del Monte, between 10 and 12 in the morning and 1 :30 to 3 :30 in the afternoon. In previous years a large number of doctors have drifted into these meetings without registering. This year only those who register, up to the number of thirty, will be admitted. This is because any greater number than this makes the meetings less profitable for everyone concerned. Please send your registration at once to the offices of the California Medical Association if you intend to be present. Do not register and hold someone else from a position if you do not intend to come.

The following is the formal program:

10 : 00–12 : 00 a. m.—*Diagnostic Problems.*
  Brain Tumor Problem—R. S. Stone, San Francisco.
  Pulmonary Malignancy Problem—R. A. Carter, Los Angeles.
  Intestinal Malignancy Problem—H. D. Snure, Los Angeles.
  Bone Malignancy Problem—C. B. Bowen, Oakland.
1 : 30–3 : 30 p. m.—*Therapeutic Problems.*
  Lip Cancer Treatment Problem—O. S. Cook, Sacramento.
  Bladder Cancer Treatment Problem—O. N. Meland, Los Angeles.
  Uterine Cancer Treatment Problem—Lyle C. Kinney, San Diego.
  Breast Cancer Treatment Problem—E. Liljencrantz, San Francisco.

We believe this to be a very worth-while program and hope that you will be able to attend.

Please make reservation with the chairman of the committee arranging the meeting, Dr. L. H. Garland, 450 Sutter Street, San Francisco.

V—ENTERTAINMENT[*]

(For places and hours of luncheons, and other entertainment features, such as golf, horses, swimming, skeet shooting, consult the bulletin boards in the lobby near the hotel desk. See also under "X—Del Monte and Monterey Peninsula," for additional information concerning outing attractions.)

Sunday:

Golf.[†]
Swimming.
Horses.

Tuesday Evening:

Dinner to President William W. Roblee, Hotel Del Monte, 7 : 30 p. m., main dining room. Reservations for plates should be made at the hotel desk by noon on Tuesday. Guests of Hotel Del Monte will sign regulation cards at the tables. Reservations for tables should be made with the dining-room captain, Mr. Carter. Plate tickets are $2.50 each.

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[*] For entertainment features sponsored by the Woman's Auxiliary, see program of Woman's Auxiliary.

[†] California Medical Association Golf Tournament.—The annual Golf Tournament of the California Medical Association will be held at Del Monte on Tuesday afternoon, May 2. At the last tournament at Del Monte, in 1937, over one hundred and fifty doctors played. It is hoped that this number will be exceeded this year. The hotel course is in splendid shape, and Peter Hay and Dr. H. R. Lusignan of Del Monte, are working hard on the local arrangements. All members of the California Medical Association are welcome and it is only necessary to appear on the first tee on Tuesday afternoon when foursomes will be arranged by the professional. Play will be 18 holes, medal play at handicap. Incidentally, Peter Hay knows your handicap. Doctor Lusignan is collecting the prizes.

We hope to have a North-South tournament on Sunday afternoon, April 30, to play for the California Medical Association trophy. Details will be sent out to you.

The Committee on Arrangements is:

James W. Morgan, chairman, 384 Post Street, San Francisco.
H. R. Lusignan, Monterey, representing the local Committee on Arrangements.
John W. Crossan, 1930 Wilshire Boulevard, Los Angeles.
Robert W. Langley, 1930 Wilshire Boulevard, Los Angeles.
John P. Lordan, 2007 Wilshire Boulevard, Los Angeles.
George W. Pierce, 490 Post Street, San Francisco.
Robert Kile, 490 Post Street, San Francisco.
George A. Gray, St. Claire Building, San Jose.

VI—SCIENTIFIC EXHIBITS

Garden Terrace Tent—South Front, Hotel Del Monte

A. Scientific Exhibits*

Allergy Exhibit—Edward Matzger, M.D., 909 Hyde Street, San Francisco.

Cardiac and Vascular Diseases—California Heart Association, 45 Second Street, San Francisco.

Device for Bed-Confining Fracture Patients—Stuart C. Knox, M.D., 2007 Wilshire Boulevard, Los Angeles.

Gastric Lesions—Harold Lincoln Thompson, M.D., 1930 Wilshire Boulevard, Los Angeles.

Gastroscopic Studies—Allan L. Cohn, M.D., 450 Sutter Street, San Francisco; Rubin Gold, M.D., 450 Sutter Street, San Francisco; Alfred White, M.D., 516 Sutter Street, San Francisco.

Human Rabies—Hyman I. Vener, M.D., 116 Temple Street, Los Angeles.

Hypoglycemia Associated with an Adenoma of the Pancreas—H. I. Burtness, M.D., 317 West Pueblo Street, Santa Barbara.

Medical Books: Classics in Anesthesia—Chauncey Leake, M.D., University of California, Medical School, the Medical Center, San Francisco.

Medical Building Construction—John Homer Woolsey, M.D., Woodland Clinic, Woodland.

Monroe Tidal Irrigator: Thermal Death Time of the Gonococcus—Alvin W. Folkenberg, M.D., 1893 Wilshire Boulevard, Los Angeles.

Pneumonia Control in California—W. P. Shepard, M.D., 600 Stockton Street, San Francisco.

Poison Oak and Poison Ivy—Ernest K. Stratton, M.D., 490 Post Street, San Francisco.

Postgraduate Study Activities of the San Joaquin County Medical Society—C. A. Broaddus, M.D., 905 Medico-Dental Building, Stockton.

Reconstructive Plastic and Oral Surgery—Arthur E. Smith, M.D., and James B. Johnson, M.D., 1930 Wilshire Boulevard, Los Angeles.

Renal Neoplasms—Dudley P. Fagerstrom, M.D., 710 Medico-Dental Building, San Jose.

Simplified Technique of Hysterectomy—W. H. Brownfield, M.D., 2007 Wilshire Boulevard, Los Angeles.

Surgical Treatment of Vesical Diverticula—Roger W. Barnes, M.D., 947 West Eighth Street, Los Angeles.

Synovial Membrane and the Synovial Fluid—David H. Kling, M.D., 1052 West Sixth Street, Los Angeles.

B. Films*

Elschnig Technique in Cataract, Trephine, and Cyclodialisis—William A. Boyce, M.D., 727 West Seventh Street, Los Angeles.

Medical and Surgical Films—Frank A. Lowe, M.D., 870 Market Street, San Francisco.

Metrazol Shock Therapy of the Psychoses—J. Elliott Royer, M.D., 2976 Summit Street, Oakland.

Poliomyelitis—Albert G. Bower, M.D., 1238 Dorothy Drive, Glendale.

C. Conferences on Cardiac and Vascular Disease

Sixteen half-hour clinical demonstrations and lectures in heart and circulatory disease will be presented in connection with the scientific exhibit of the California Heart Association at the annual meeting of the California Medical Association at Del Monte.

Dr. William H. Leake of Los Angeles is chairman of the committee preparing the demonstrations. Sixteen clinicians from all parts of the state will review the results of recent progress in the diagnosis and treatment of various types and manifestations of cardiac and vascular disease.

The program will begin late Monday, May 1, and continue through Tuesday and Wednesday. They are arranged so there will be no conflict with the medical sessions.

Detailed programs, giving places and hours of the conferences, will be available at the California Medical Association registration desk, and will appear in the programs to be distributed at Del Monte.

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* Tentative, partial list.

VII—COMMERCIAL EXHIBITS†

Aloe Company, A. S., 932 South Hill Street, Los Angeles. Booth No. 15.

Ayerst, McKenna & Harrison, Ltd., 781 Williams Street, Montreal, Canada. Booth No. 3.

Baxter, Don, Inc., 1505 Gardena Avenue, Glendale. Booth No. 8.

Borden Milk Company, 350 Madison Avenue, New York. Booth No. 22.

Burroughs Wellcome & Company, 9–11 East Forty-first Street, New York City. Booth No. 21.

Coca-Cola Company, Atlanta, Georgia. Booth No. 18.

Cutter Laboratories, Fourth and Parker, Berkeley. Booth No. 10.

Fischer, H. G., & Company, 2323 Wabansia Avenue, Chicago. Booth No. 20.

General Electric X-Ray Corporation, 450 Sutter Street, San Francisco. Booth No. 27.

Gerber Products Company, Fremont, Michigan. Booth No. 14.

Heinz Corporation, H. J., 2998 San Pablo Avenue, Berkeley. Booth No. 23.

Liebel-Flarsheim Company, 303 West Third Street, Cincinnati, Ohio. Booth No. 7.

Lippincott Company, 227 South Sixth Street, Philadelphia. Booth No. 11.

Mead Johnson & Company, 670 Third Street, San Francisco. Booth No. 4.

Medical Protective Company, The, Wheaton, Illinois. Booth No. 6.

Morning Milk Company, Continental Bank Building, Salt Lake City. Booth No. 9.

Mosby Company, C. V., 3523 Pine Boulevard, St. Louis. Booth No. 26.

Pet Milk Sales Corporation, St. Louis, Missouri. Booth No. 25.

Petrolagar Laboratories, Inc., Chicago. Booth No. 17.

Philip Morris & Company, Ltd., 119 Fifth Avenue, New York. Booth No. 13.

Sandoz Chemical Works, 450 Sutter Building, San Francisco. Booth No. 2.

Schering Corporation, Bloomfield, New Jersey. Booth No. 16.

Stacey, J. W., Incorporated, Flood Building, San Francisco. Booth No. 1.

E. R. Squibb and Sons, 745 Fifth Avenue, New York. Booth No. 7.

Travers & Henning, Inc., 429 Sutter Street, San Francisco. Booth No. 19.

White Laboratories, Inc., 113 North Thirteenth Street, Newark, New Jersey. Booth No. 12.

Wyeth & Brother, John, 1118 Washington Avenue, Philadelphia. Booth No. 24.

Zweegman School for Medical Secretaries, 450 Sutter Street, San Francisco. Booth No. 5.

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† This is a tentative list of the exhibitors. Complete information will appear in the annual session program.

MRS. CLIFFORD A. WRIGHT
President, Woman's Auxiliary to the
California Medical Association
1938-1939

MRS. G. WENDELL OLSEN
Recording Secretary, Woman's Auxiliary
to the California Medical Association
1938-1939

VIII—WOMAN'S AUXILIARY

Tenth Annual Session

WOMAN'S AUXILIARY TO THE CALIFORNIA MEDICAL ASSOCIATION

Headquarters at Hotel Del Monte, Del Monte

Mrs. Clifford A. Wright, *President*

Mrs. Lawrence M. Knox, *Convention Chairman*

Sunday, April 30

Arrival of delegates, members and guests, greeted by delegation hostesses.

3:00–5:00 p.m.—Registration at registration desk.

4:00 p.m.—Informal tea in Hotel Del Monte Lounge.

7:30–9:30 p.m.—Registration.

Monday, May 1

8:45 a.m.—Pre-Convention State Board meeting in the Tower Room, Hotel Del Monte.

9:30 a.m. to 4:00 p.m.—Registration.

10:00 a.m.—First general meeting of the California Medical Association. All Auxiliary members and wives of doctors are invited to attend.

12:30 p.m.—Informal luncheon at Hotel Del Monte, with local hostesses presiding.

2:00 p.m.—Motor trips to interesting points on the Monterey Peninsula. Historic and Garden tours.

9:00 p.m.—Reception and musicale in honor of Mrs. William W. Roblee, wife of the president of the California Medical Association, to be held in the Copper Cup Room of the Hotel Del Monte. Members of the State Board will serve on the Reception Committee.

Tuesday, May 2

9:00 a.m. to 1:00 p.m.—Registration.

9:30 a.m.—First general session of the tenth annual convention at Del Monte Lodge, Mrs. Clifford A. Wright, presiding.

1:00 p.m.—Luncheon at Del Monte Lodge in honor of Mrs. Clifford A. Wright, with Mrs. Thomas J. Clark presiding. Speaker, Dr. George H. Kress. Members of the State Advisory Board will be guests of honor.

7:30 p.m.—President's dinner and dance of the California Medical Association at Hotel Del Monte.

Wednesday, May 3

9:00–11:00 a.m.—Registration.

9:30 a.m.—Second general session of the tenth annual convention at Del Monte Lodge, Mrs. Clifford A. Wright presiding. Election of officers.

1:00 p.m.—Luncheon at Del Monte Lodge in honor of Mrs. Frederick N. Scatena, with Mrs. Hobart Rogers presiding. Speaker, Dr. J. B. Harris.

2:30 p.m.—Women's Golf Tournament.

3:00 p.m.—Post-Convention State Board meeting.

President's Report

To the Members of the Auxiliary:

The annual convention of the California State Medical Association in Pasadena last May, and the American Medical Association meeting in San Francisco later, demonstrated to the women of the Auxiliary the real importance of our organization. Many of the women realized as never before just how far-reaching our influence had become. The opening meeting of the American Medical Association convention in the beautiful San Francisco Auditorium made an impression on those who were fortunate enough to attend that will never be forgotten. The splendid men at the head of the American Medical Association inspired the confidence and admiration of all those present. We can justly take pride in belonging to an Auxiliary to this great body of men.

Our endeavors this year embrance friendship, public relations, public speaking, the *Courier,* a state library, *Hygeia,* and membership.

This year we have been continuing the health education program similar to that given us last year. Our women are very active in every club—civic and educational—in each community. The Parent-Teacher Association is one of our best fields for spreading health education and preventive medicine. We are proud that our women are well represented in this organization.

Last fall the counties were asked to form public-speaking classes. In some cases this work has been especially noteworthy. The classes were resolved into study groups, paying special attention to subject matter of which they need to be well informed.

We think a well-informed woman who is never belligerent but always gracious and well poised is a splendid representative for the noble profession we serve. This idea has been carried out with good results.

Several plays have been written and presented by the members. The San Diego Auxiliary made such success of the Christmas play that they were asked to repeat it on two occasions. The play has been placed on file in the State Library, and is available for any who may want to use it.

The *Courier* has attained quite an important place in this state. It is published at great effort on the part of the editor and her committee, and at considerable expense, but if it does help in promoting interest in the organization throughout the state it is well worth the effort and expense. Mrs. Charles C. Tomlinson, the National president, and several National officers, to whom copies were sent, have been very complimentary in expressing their appreciation of our journal.

The State Library is giving us considerable worry. We have some very desirable books, but get very few requests for them. If the Library is to have any value it must be used. A list of books in the Library was sent to every state officer last fall, with the urgent request that they be read. Of course, these same books are in the home libraries of many of our members, and are easily obtained in public libraries nearer at hand, so it is not difficult to understand why our State Library has not been more popular. County presidents have been asked to have at least one of our books reviewed by a member at an Auxiliary meeting during the year. Many counties have complied with this request. We hope all will have done so by the end of the year.

Hygeia continues to become more popular. The Rogers plan for increasing circulation was approved by the Auxiliary State Board, and we hope to have some marked results from this plan before long.

Terrace: Overlooking one of the Sunken Gardens

We are anticipating the organization of a new county auxiliary in Modesto, in Stanislaus County.

The doctors have given us much credit for the defeat of the "Humane Pound Act."

The State Council has approved the cancer control campaign, and has asked that the women of the Auxiliary take an active part. Plans are now being made for the drive which is to be put on in April.

We hope to continue to be good-will ambassadors in the cause of scientific medicine as we go about our Auxiliary work.

Respectfully submitted,

Mrs. Clifford A. Wright, *President.*

WOMAN'S AUXILIARY TO THE CALIFORNIA MEDICAL ASSOCIATION

CONVENTION COMMITTEES

Mrs. Lawrence M. Knox, *General Chairman*

Credentials and Registration

Mrs. Eric Larson, Chairman
Mrs. A. A. Arehart, Local Chairman
Mrs. Raymond V. Rukke, Vice-Chairman
Mrs. Martin McAulay Miss Bertha Merrill

Information

Mrs. Garth Parker, Chairman
Mrs. Roy M. Fortier

Transportation and Sightseeing

Mrs. H. Spencer Hoyt, Chairman
Mrs. W. D. Meyenberg

Hospitality

Mrs. Rudolph O. Griess, Chairman
Mrs. W. M. Gratiot Mrs. J. P. Sandholdt
Mrs. H. M. Stufflebam

Entertainment

Mrs. Herbert Archibald, Chairman
Mrs. Marshall Carter, Vice-Chairman
Mrs. H. N. Yates, Chairman of Reception and Musicale
Mrs. W. H. Farr, Chairman of Tuesday Luncheon
Mrs. J. C. Sharp, Chairman of Wednesday Luncheon
Mrs. Frank Wiebe, Chairman of Golf Tournament

Decorations and Flowers

Mrs. James McPharlin, Chairman
Mrs. John H. Gratiot Miss Barbara Yates

Headquarters

Mrs. Martin McAulay, Chairman
Mrs. W. H. Lawler

Ushers and Pages

Mrs. Arthur L. Wessels, Chairman
Mrs. Winton F. Swengel

Supplies and Printing

Mrs. G. Eberhardt, Chairman
Mrs. Mast Wolfsohn

Finance

Miss Julia Koenecke, Chairman
Miss Bertha Merrill Mrs. John H. Gratiot

Publicity

Mrs. F. Hilton Smith, Chairman
Mrs. W. F. Coughlin

Emergency and Aides to General Chairman

Mrs. Raymond V. Ruppe, Chairman
Auxiliary members of the five counties comprising the Fifth District will act in this capacity.

IX—RAILROAD INFORMATION

Ticket Agents of principal rail lines in California, on presentation and surrender of identification certificates, will sell round-trip tickets to Del Monte or Monterey, Calif., costing approximately 1¼c per mile, which is the first-class one-way fare. Tickets will be sold from April 26 to May 4, 1939, inclusive. Return limit date being May 14, 1939. Stopovers allowed. If longer return limit is desired, consult railroad ticket agent at Del Monte or Monterey prior to May 14, 1939.

Following are examples of fares to Del Monte and illustrate the extent of reduction:

From	One Way 1st Class	One Way Coach	Convention Round Trip	30-Day Round Trip Coach	21-Day Round Trip 1st Class
San Francisco	$ 3.70	$ 2.47	$ 3.70	$ 4.45	$ 4.90
San Jose	2.25	1.50	2.25	2.70	3.00
Los Angeles	11.45	7.64	11.45	13.76	15.15

If you cannot obtain a copy of the certificate from your County Society Secretary, send a stamped, self-addressed envelope to the California Medical Association, 450 Sutter Street, San Francisco, with request for a Railroad Convention Rate Certificate (which *must* be presented to the ticket agent at the time the ticket is purchased).

RAILROAD SERVICE*

	Daylight	*Southbound* Express	Sunset	
Leave San Francisco	8:15 a. m.	4:00 p. m.	8:00 p. m.	
Arrive Del Monte	11:09 a. m.	6:50 p. m.	11:20 p. m.	
		Northbound		
Leave Los Angeles	8:15 a. m.	6:05 p. m.		
Arrive Del monte	4:21 p. m.	7:25 a. m.		
Leave Santa Barbara	10:35 a. m.	9:05 p. m.		
Arrive Del Monte	4:21 p. m.	7:25 a. m.		
Leave San Diego	9:01 a. m.	12:45 p. m.	7:55 p. m.	11:30 p. m.
Arrive Los Angeles	12:30 p. m.	3:15 p. m.	10:25 p. m.	3:00 a. m.

Service afforded by Daylight Limited, the Del Monte and Sunset from San Francisco. Service from Southern California Service by Daylight Limited and Coaster. Time tables here given are those of the Southern Pacific Company.

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* Check with time table or ticket agent.

GREYHOUND BUS SCHEDULE†

From *Oakland* to *Del Monte* (Hotel)

One Way, $2.45; Round Trip, $4.45

Lv. *Oakland*	Ar. *Del Monte*	Lv. *Del Monte*	Ar. *Oakland*
8:10 a. m.	12:06 p. m.	9:45 a. m.	2:05 p. m.
10:40 a. m.	4:20 p. m.	2:50 p. m.	8:28 p. m.
3:40 p. m.	7:30 p. m.	6:05 p. m.	10:40 p. m.
5:25 p. m.	9:25 p. m.		
7:30 p. m.	11:25 p. m.		

From *San Francisco* to *Del Monte* (Hotel)

One Way, $2.20; Round Trip, $4.00

Lv. *San Francisco*	Ar. *Del Monte*	Lv. *Del Monte*	Ar. *San Francisco*
8:15 a. m.	12:06 p. m.	9:45 a. m.	2:05 p. m.
11:30 a. m.	4:20 p. m.	2:50 p. m.	7:35 p. m.
3:30 p. m.	7:30 p. m.	6:05 p. m.	10:35 p. m.
5:25 p. m.	9:25 p. m.		
7:30 p. m.	11:25 p. m.		

From *Los Angeles* to *Del Monte*

One Way, $5.40; Round Trip, $9.75

Lv. *Los Angeles*	Ar. *Del Monte*	Lv. *Del Monte*	Ar. *Los Angeles*
8:00 a. m.	7:30 p. m.	10:58 a. m.	10:40 p. m.
11:30 a. m.	9:25 p. m.	6:05 p. m.	5:10 a. m.
12:30 a. m.	12:06 p. m.		

From *San Diego* to *Del Monte*

One Way, $6.95; Round Trip, $12.55

Lv. *San Diego*	Ar. *Del Monte*	Lv. *Del Monte*	Ar. *San Diego*
6:45 a. m.	9:25 p. m.	10:58 a. m.	5:00 a. m.
7:45 p. m.	12:06 p. m.	6:05 p. m.	10:00 a. m.

From *Bakersfield* to *Del Monte*

One Way, $5.85; Round Trip, $10.55

Lv. *Bakersfield*	Ar. *Del Monte*	Lv. *Del Monte*	Ar. *Bakersfield*
8:30 a. m.	9:25 p. m.	9:45 a. m.	2:15 a. m.
11:15 a. m.	11:25 p. m.	2:50 p. m.	5:25 a. m.
1:00 a. m.	12:06 p. m.		

From *Fresno* to *Del Monte*

One Way, $4.36; Round Trip, $7.85

Lv. *Fresno*	Ar. *Del Monte*	Lv. *Del Monte*	Ar. *Fresno*
12:30 p. m.	9:25 p. m.	9:45 a. m.	8:05 p. m.
2:40 p. m.	11:25 p. m.	2:50 p. m.	2:35 a. m.
3:50 a. m.	12:06 p. m.		

From *Eureka* to *Del Monte*

One Way, $8.05; Round Trip, $14.50

Lv. *Eureka*	Ar. *Del Monte*	Lv. *Del Monte*	Ar. *Eureka*
7:00 p. m.	11:09 a. m.	2:50 p. m.	6:20 a. m.
7:40 a. m.	11:25 p. m.	6:05 p. m.	6:20 p. m.

(Over night in San Francisco)

From *Santa Barbara* to *Del Monte*

One Way, $4.10; Round Trip, $7.40

Lv. *Santa Barbara*	Ar. *Del Monte*	Lv. *Del Monte*	Ar. *Santa Barbara*
12:20 p. m.	7:30 p. m.	10:58 a. m.	6:45 p. m.
2:27 p. m.	9:25 p. m.	6:05 p. m.	2:05 a. m.
3:45 a. m.	12:06 p. m.		

From *Stockton* to *Del Monte*

One Way, $2.75; Round Trip, $4.95

Lv. *Stockton*	Ar. *Del Monte*	Lv. *Del Monte*	Ar. *Stockton*
7:30 a. m.	12:06 p. m.	9:45 a. m.	4:15 p. m.
1:55 p. m.	7:30 p. m.	2:50 p. m.	9:10 p. m.
4:45 p. m.	9:25 p. m.		
6:35 p. m.	11:25 p. m.		

From *Sacramento* to *Del Monte*

One Way, $3.65; Round Trip, $6.60

Lv. *Sacramento*	Ar. *Del Monte*	Lv. *Del Monte*	Ar. *Sacramento*
6:00 a. m.	12:06 p. m.	9:45 a. m.	6:20 p. m.
12:20 p. m.	7:30 p. m.	2:50 p. m.	11:10 p. m.
3:10 p. m.	9:25 p. m.		
5:00 p. m.	11:25 p. m.		

From *Sacramento* to *Del Monte* via *San Francisco*

One Way, $4.00; Round Trip, $7.20

Lv. *Sacramento*	Ar. *Del Monte*	Lv. *Del Monte*	Ar. *Sacramento*
5:00 a. m.	12:06 p. m.	9:45 a. m.	5:55 p. m.
6:50 a. m.	4:20 p. m.	2:50 p. m.	11:50 p. m.
11:20 a. m.	7:30 p. m.	6:05 p. m.	3:35 a. m.
12:50 p. m.	9:25 p. m.		
3:25 p. m.	11:25 p. m.		

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† It may be desirable to inform local ticket office, to insure adequate accommodations.

AIR SHIPS*

Leave San Diego	11:15 a. m.
Leave Long Beach	11:55 a. m.
Arrive Los Angeles	12:15 p. m.
Leave Los Angeles	2:30 p. m.
Leave Santa Barbara	3:14 p. m.
Arrive Del Monte	4:33 p. m.
Leave San Francisco	9:50 a. m.
Arrive Del Monte	10:33 a. m.

Fares from following cities to Del Monte:

	One Way	*Round Trip*
Los Angeles	$16.30	$29.34
Long Beach	19.25	34.64
San Diego	22.30	40.14
Santa Barbara	11:30	20.34
San Francisco	4.70	8.46

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* Schedules are those of the United Air Lines.

Convention Rate Certificates—Additional Information

For this convention, special round-trip intrastate convention fares from points on all principal rail lines in California to Del Monte will be authorized on the identification-certificate plan. . . .

Round-trip convention fares referred to *will not apply* from points outside of California or for *interstate* trips; however, for interstate traffic thirty-day round-trip intermediate-class and coach-class tickets, also 21-day first-class tickets are available.

Certificates should be furnished *only to members of the organization* with names of those to whom furnished entered thereon with pen and ink or typewriter.

In order that members of the organization may know of the very low round-trip fares and liberal return limit of May 14, the interested rail lines will very much appreciate your including the following paragraph in the circular or bulletin of convention arrangements which is sent to members of the organization.

Round-Trip Rail Convention Fares and Arrangements

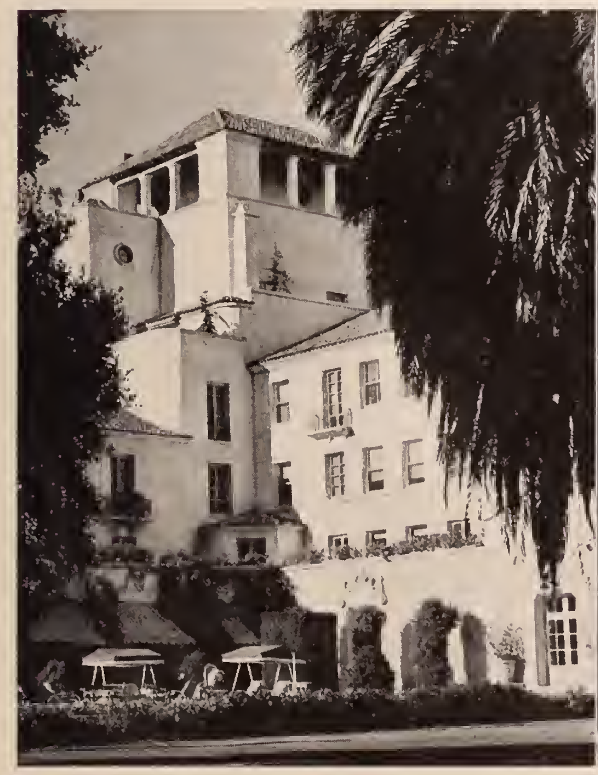
Ticket agents of principal rail lines in California, on presentation and surrender of identification-certificates, will sell round-trip tickets to Del Monte, and the certificates which you will later receive, entitling you to reduced fares, will show on the reverse side the convention fares that will apply to Del Monte from principal California points. Tickets at these convention fares are of three classes as follows:

(a) *First Class:* Tickets at first-class fares will be on basis of first-class one-way adult fare for the round trip, and will be honored in coaches and chair cars, also in sleeping cars, parlor and reserved-seat cars on payment of charge for space occupied.

(b) *Intermediate Class:* Tickets at intermediate (tourist) class fares will be on basis of 85 per cent of the first-class one-way adult fare for the round trip, and will be honored in coaches and chair cars, also in tourist sleeping cars and reserved-seat cars where operated on payment of charge for space occupied.

(c) *Coach Class:* Tickets at coach-class fares will be on basis of 75 per cent of the first-class one-way adult fare for the round trip, and will only be honored in coaches and chair cars.

Tickets will be on sale from April 26 to May 4, inclusive, and return limit will be May 14. Stopovers allowed. If longer return period is desired, consult railroad ticket agent prior to May 14.



An unusual view of Hotel Del Monte seen through the trees of its vast park.

The Roman Plunge, children's pool, tennis courts, and Laguna del Rey as seen from the Tower Room at Del Monte.

X—DEL MONTE AND THE MONTEREY PENINSULA

DEL MONTE: ENTERTAINMENT FEATURES

An observing traveler once said that Del Monte is all things—at once. His description, however brief, does not come far from the mark. For within Del Monte's vast estate of 20,000 acres is nearly every description of recreation and sport imaginable.

Golf.—Would you golf? Within a three-mile radius of Del Monte are five courses: more, in such a concentrated area, than is to be found elsewhere in the world. One of these courses, famous Pebble Beach, was the scene in 1929 of the National Amateur championship. At that time Bobby Jones called it the most picturesque and playable layout of his experience. Cypress Point, Del Monte. the Monterey Peninsula Country Club courses, and Pacific Grove's fine municipal course complete the list.

Tennis.—Is tennis your sport? Del Monte has eleven courts. Every June witnesses the Del Monte tennis championship, when fine players from all parts of the Coast gather to match their skill.

Trapshooting.—Do you go in for trapshooting? Del Monte has the largest and one of the best equipped set of traps in the country. Official gathering place of the Pacific International Trapshooting Association, the Del Monte grounds present the sport at its best. State and sectional tournaments are held there annually as well as the yearly sports powwow of the California Indians in April.

Fishing and Hunting.—Perhaps your sport is fishing. Or hunting. There, too, Del Monte offers the best to be found. But one hour by motor from Del Monte, up the Carmel Valley, is San Clemente, Del Monte's guest ranch. Adjoining and extending into the great national forest that lies between the Salinas Valley and the Coast, San Clemente offers the nimrod and hunter their heart's desire. Then, of course, there are the world-famous waters of Monterey and Carmel bays for deep-sea fishermen.

Swimming.—Perhaps your favorite pastime is swimming, and the popular and healthful fad of sun bathing. Del Monte provides complete facilities to satisfy your desires. The Roman Plunge in the beautiful and spacious hotel park has heated salt water and is open the year round, with a smaller and safe plunge for children. The Beach Club at Pebble Beach has an open-air tank at the water's edge. Then there are the white sandy beaches on Monterey and Carmel bays and the Pacific Ocean to enjoy surf bathing, and the ol' swimmin' hole at the Monterey Peninsula Country Club is another favorite spot.

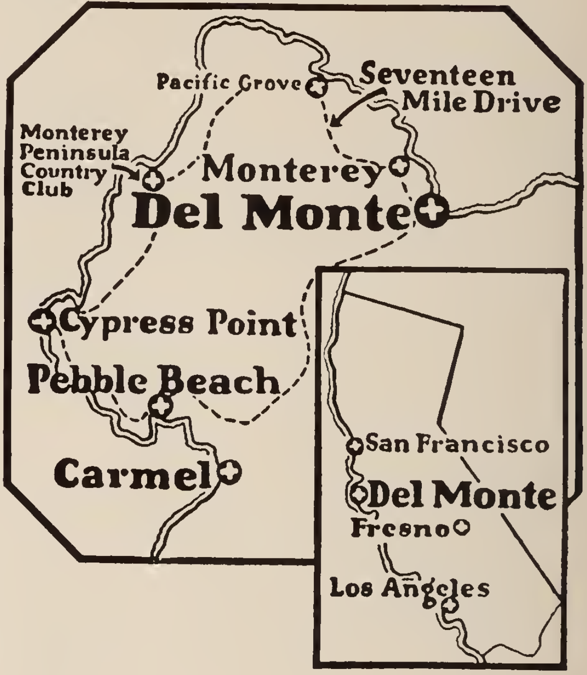
Trails.—Have you tried the bridle paths at Del Monte? If not, you have missed a treat. There are more than one hundred miles of privately owned and signed scenic paths in the forest and along the beaches. A stable of fine mounts is maintained. By all means bring your riding togs.

⁂

MONTEREY

Monterey Peninsula is richly endowed with travel interest. Here are attractions for everyone. Historic-minded motorists who travel with guide book and camera, and others who merely poke around for the fun that is in it, both find their heart's desire within California's famous "Circle of Enchantment."

Good roads, clearly marked, lead the willing motorist to points of special charm and reveal vistas and scenes which artists have chosen to proclaim the most beautiful anywhere. A trip to the Monterey Peninsula and along the Coast to the Big Sur may indeed be called a trip so memorable as never to be forgotten.



The city of Monterey is in itself enough reward for having made the trip. Monterey was discovered by the Spaniard, Cabrillo, in 1542. He called it "Bay of the Pines." and as such was it known until 1602, a decade before the Pilgrims landed on eastern shores, when Viscaino rediscovered it and called it Monterey (King of the Forests) after the Compte de Monterey, then Viceroy of Mexico. Over a century and a half elapsed before white men again set foot on the soil of California. Then came Portola in 1770, who established the Monterey Presidio, and Padre Junipero Serra, who founded the San Carlos Mission.

Monterey was a gay place under Spanish rule. All the glamor of old Spain held forth then, and life there was a perpetual care-free fiesta. In 1821 Mexico threw off the Spanish yoke and a period of unrest followed, culminating in 1846, when Commodore Sloat raised the Stars and Stripes over the historic Customs House, and Monterey became an American possession.

Monterey abounds with historic and beautiful points of interest. Visitors there would do well not to miss the following landmarks: *San Carlos Church,* founded in 1770 by Junipero Serra and once the place of worship for representatives of the Spanish throne, governors, and Presidio officers; *Monterey Presidio,* established by Portola in 1770 and prominent throughout Monterey's history; *First Theater in California,* used by picturesque strolling players as early as 1847. The *Customs House,* over which have flown the flags of Spain, Mexico, and the United States; *Colton Hall,* first capitol building of California. Here was drafted the constitution of California. *Stevenson House:* The beloved Robert Louis Stevenson spent three months here in 1879, and wrote one or two of his memorable works in Monterey. Praise of Monterey and its coast is to be found in some of his books.

Seventeen-Mile Drive.—No trip to the Monterey Peninsula is complete, of course, without including the world-famous Seventeen-Mile Drive. The combination of pines, age-old cypress, and the sparkling blue of the Pacific, is one that hundreds of artists have honored with their canvases.

Part II

PRE-CONVENTION BULLETIN*

FOREWORD.—The official reports which follow will be presented at the coming session of the House of Delegates.

Delegates, therefore, are urged to familiarize themselves with their contents.

Members, likewise, are requested to become familiar with the recommendations in these reports, and to discuss them with other members and delegates.

* * *

I

REPORTS OF GENERAL OFFICERS

REPORT OF THE PRESIDENT

To the Members of the House of Delegates and the Members at large of the California Medical Association:

Your President has visited and conferred with all the County Societies of Northern and Central California, either singly or in joint meetings. The Southern California visitations were made by President-elect Dukes, accompanied in some instances by the President.

The President has attended all meetings held by the Council, Executive Committee and the special session of the House of Delegates. A report of his official findings and recommendations will be given in his address at the first general session of the annual meeting at Del Monte.

He is most appreciative of the expressions of cordiality and good will that have been extended to him, both officially and personally. It has been a busy and a very happy year.

Respectfully submitted,
W. W. Roblee, *President.*

REPORT OF THE PRESIDENT-ELECT

To the President and the House of Delegates:

It has been my pleasure to attend several meetings of County Medical Societies with the President, Doctor Roblee; Councilors Gilman, Rogers, Packard, Howson, Kiger and Emmons.

The southern counties were visited, at the request of Doctor Roblee, and at all of these meetings the Secretary-Editor was a speaker. The counties visited were Imperial, Orange, Riverside, San Bernardino and San Diego, Los Angeles (meetings at Pasadena and Los Angeles), Kern, Ventura and San Luis Obispo, and there was also a luncheon at Santa Maria at which the topic of medical service was discussed. A cancer clinic, too, at San Bernardino County Hospital was attended.

The attendance and interest shown by the members and the Woman's Auxiliary in both the scientific and economic problems is a very encouraging commentary on the work being done by the Officers and Councilors of the California Medical Association.

Your President-elect has also spoken before many lay groups on the California Physicians' Service.

Respectfully submitted,
Charles A. Dukes, *President-elect.*

REPORT OF THE SPEAKER OF THE HOUSE OF DELEGATES

To the President and the House of Delegates:

During the past year your Speaker has attended the meetings of the Council and the Executive Committee, of which bodies he is ex officio, a member. He has performed such special committee duties as have been assigned to him; which duties, during the past year, have been unusually heavy.

The House of Delegates will convene promptly at 8 p. m. on Monday, May 1. Its second meeting will be on Wednesday, May 3. The Speaker urges all delegates to be in their seats at the hour of convening, and takes this occasion to remind the delegates that they have assumed very serious duties in accepting office. These duties are not to be taken lightly, and, even though some small personal sacrifice is demanded, the responsibility of a delegate is such that the inconvenience to himself is to be borne as the price of his office.

The Speaker also wishes to urge all delegates and alternates to read the Pre-Convention Bulletin carefully in order that they may be familiar with the work and the problems of their organization.

Respectfully submitted,
Lowell S. Goin, *Speaker.*

REPORT OF THE VICE-SPEAKER OF THE HOUSE OF DELEGATES

To the President and the House of Delegates:

The duties of the Vice-Speaker during the past year have been of the lightest and most pleasant nature. Due to the outstanding ability of the Speaker of the House of Delegates, his subordinate is quite free from either anxiety or care.

Respectfully submitted,
John H. Graves, *Vice-Speaker.*

REPORT OF THE CHAIRMAN OF THE COUNCIL

To the President and the House of Delegates:

The Chairman of the Council feels that to enumerate the actions and discussions of the Council of the California Medical Association for the past year would be nothing but repetition, and would needlessly take the time of the delegates from other important business. The proceedings of all the meetings of the Council have been printed in CALIFORNIA AND WESTERN MEDICINE, and are available to anyone who cares to peruse them.

There are only two things to which your attention is especially directed at this time. The first and most important is that never before has there been a greater need for unity of action and solidarity in organized medicine. The very existence of our profession may depend upon the ability of the individual to forget himself, and so to take his place beside the other members of the organization with the determination not only to coöperate, but to make sacrifices.

The second point for your serious consideration is the state of finances of the Association. The past year has been costly in many ways, and the receipts for the current year are not sufficient to refill the depleted coffers. There are many expenses that were unknown to us a few years ago and which now cannot be avoided. Funds to meet the new problems which are constantly arising should be provided, and the utmost economy must be practiced by those who are charged with the responsibility of expenditures.

There must be a united effort to make progress, and it may be that our present trials may later be found to have been the fire which gave us not only new metal but, with it, temper and strength.

The annual report of the Council will be presented at the first meeting of the House of Delegates.

Respectfully submitted,
Karl L. Schaupp, *Council Chairman.*

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* Section 3, Article XII, of the California Medical Association Constitution states, in part: "The Association, prior to the annual session, shall print a 'Pre-Convention Bulletin,' which shall contain reports of officers and committees. . . . A copy of the 'Pre-Convention Bulletin' shall be given to each delegate and alternate on or before registration."

REPORT OF SECRETARY-TREASURER

To the President and the House of Delegates:

Your Secretary-Treasurer begs leave to submit his report under two subheadings: (1) Report of the Treasurer; and (2) Report of the Secretary.

* * *

I. Report of the Treasurer

The following statement of income, expenditures and resources, as certified by the licensed, bonded public accountants (Ernst & Ernst), gives a summary of the year's financial operations:

I

CALIFORNIA MEDICAL ASSOCIATION

INCOME AND EXPENDITURES*

For the period December 18, 1937, to December 31, 1938

INCOME

Dues and General		
Membership dues	$60,035.50	
Exhibits and annual meeting (less installation cost)	2,528.01	
California Medical Association—Services	600.00	
Interest earned	247.68	
Reprint sales—net	473.85	
Miscellaneous	259.56	
		$ 64,144.60
Official Journal—CALIFORNIA AND WESTERN MEDICINE		
Advertising	$24,398.60	
Cash subscriptions	665.03	
		25,063.63
Total income		$89,208.23

EXPENDITURES

Administrative	$48,868.16	
Scientific, educational and public relations	20,599.75	
Official Journal—CALIFORNIA AND WESTERN MEDICINE	41,483.32	
		110,951.23
Excess in expenditures		$21,743.00

* * *

EXPENDITURES

For the period December 18, 1937, to December 31, 1938

(*a*)—ADMINISTRATIVE

Secretary, Treasurer and Director of Public Relations:		
Salary	$10,500.00	
Settlement	7,000.00	
Salaries—clerical	6,218.49	
Travel expense:		
Secretary, Treasurer and Director of Public Relations	234.79	
Officers	641.84	
Council	1,408.97	
Executive Committee	108.10	
A. M. A. Delegates	130.75	
Taxes—payroll	1,502.67	
Annual meeting expense	2,702.82	
Special meeting expense	3,459.54	
Legal expense:		
Retainer	4,000.00	
Other legal expenses	883.63	
Rent	3,425.00	
Office supplies and expenses	1,919.39	
Postage	765.00	
Directory	432.00	
Telephone and telegraph	797.79	
Council and committee expense	376.79	
Office equipment expense	156.05	
Miscellaneous	2,214.54	
		$ 48,868.16

(*b*)—SCIENTIFIC, EDUCATIONAL AND PUBLIC RELATIONS

California Society for Promotion of Medical Research	$ 7,000.00	
State Humane Pound Act	7,423.69	
Contributions to Medical Libraries	1,532.50	
Public Policy Expenses	2,400.00	
Other Committee Activities	2,243.56	
		20,599.75

(*c*)—OFFICIAL JOURNAL—CALIFORNIA AND WESTERN MEDICINE

Printing	$26,299.31	
Salary—editor	4,166.66	
Salaries—clerical	2,312.50	
Advertising commissions	3,198.11	
Wrapping and mailing	1,346.32	
Illustrations	425.45	
Supplies, expense and office postage	750.56	
Discounts and collection expense	255.84	
Provision for doubtful accounts	112.37	
Sales tax (including prior years' tax)	2,616.20	
		41,483.32
Total expenditures		$110,951.23

* * *

II

TRUSTEES OF THE CALIFORNIA MEDICAL ASSOCIATION

BALANCE SHEET

December 31, 1938

ASSETS

Cash:			
On deposit:			
Commercial account:			
Bank of America N. T. & S. A.		$ 353.77	
Savings accounts:			
Bank of America N. T. & S. A.	$3,738.41		
Crocker First Federal Trust	2,160.63		
The San Francisco Bank	770.50		
		6,669.54	
			7,023.31
Marketable Securities:			
U. S. Government securities—at cost (pledged $20,253.13)		80,073.45	
Accrued interest		1,073.69	
			81,147.14
Loans to California Medical Association			20,000.00
			$108,170.45

LIABILITIES AND SURPLUS

Notes payable to bank (Secured by bonds costing $20,253.14)			20,000.00
Members' contributions to Endowment Fund			200.00
Surplus:			
Contributed surplus:			
Received from California Medical Association		75,000.00	
Earned surplus:			
Balance at December 19, 1937	10,581.24		
Net income for the period December 19, 1937, to June 30, 1938	1,202.14		
Net income for period July 1, 1938, to December 31, 1938	1,187.07		
		12,970.45	
			87,970.45
			$108,170.45

* * *

INCOME AND EXPENDITURES

For the period December 19, 1937, to December 31, 1938

INCOME

Interest on bonds	$2,483.38	
Interest on savings accounts	111.33	
Interest on loans	80.83	
		$2,675.54

EXPENDITURES

Miscellaneous	286.33	
		286.33
Net income		$2,389.21

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* Figures are taken from the report of the Certified Public Accountants.

COMMENT

The moneys of the California Medical Association may be said to be classified or held in three funds: (1) Administrative (California Medical Association); (2) Reserves ("Trustees Of The California Medical Association"); (3) Custodial (Indemnity Defense Fund). The current maintenance is the first or administrative fund, the chief sources of income for this allocation being the dues from 6,100 members, plus the advertising income from the official journal, CALIFORNIA AND WESTERN MEDICINE. The second or reserve fund contains the resources vested in the separate corporation known as the "Trustees Of The California Medical Association," * a body that came into existence in May, 1930, with function to hold in trust certain reserve resources transferred into its keeping from time to time by the Council of the California Medical Association. The third fund (Indemnity Defense Fund) consists of a partial or residual interest in moneys to be held in trust until about November, 1944. The "Indemnity Defense Fund" † represents the balance in the treasury on December 1, 1923, of that separate group that was organized in the year 1916 to aid in the protection of physicians who might have adverse verdicts, with indemnity judgments, rendered against them. The physicians who had joined this group voluntarily paid ten dollars annually to provide additional indemnity defense for themselves in case of malpractice suit verdicts. It was found necessary to discontinue the plan in 1923. Since that year, many of the members have assigned whatever residuary interest they might have in the fund to the California Medical Association. In 1944 or 1945 it is possible that fund will be liquidated. It is kept intact until the youngest minor on whose behalf a suit could be filed will have reached the age of twenty-one.

The reports of the bonded public accountants (Ernst & Ernst) will be submitted at the annual session to the Reference Committees.

* * *

From the above it is seen that, for practical purposes, the first, or administrative fund, is the one from which an insight of the Association's yearly income and expenditures may be gleaned, and concerning that fund further comments are here made.

In the matter of the California Medical Association expenditures, it is well to keep in mind that in December of each year the Auditing Committee of the Association prepares a tentative budget to cover the fiscal year, which begins at the close of the succeeding annual session. The Executive Committee and Council consider the proposed budget so presented, the Council then submitting it to the House of Delegates for changes and final approval. Recently, succeeding budgets for fiscal years have been in such close relationship that, for practical purposes, they can be used for fiscal years, as regards general comment.

The budget figures adopted in Pasadena in May, 1938, when applied to the calendar year 1938, reveal the following: The total estimated income in the budget ($94,100) exceeded the actual income by $1,192.62 (total income was $92,907.38; estimated budget income was $94,100).

As regards expenditures, the special expenses listed below (of $28,520.85, as noted in the financial report for the twelfth calendar month, December, 1938, under Item 36) were not provided for in the budget of anticipated expenditures.

If these special expenses had not been counted, then the total of all other maintenance expenditures ($82,941.24) would have been considerably less than the amount anticipated and provided for in the budget, for the total estimated expenditures as given in the budget was $88,100 (or adding thereto $6,000 of estimated unexpended balance, $94,100), but only $82,946.24 was actually expended against the various items (Items 8 to 35, inclusive), leaving an unexpended balance or net of $5,173.76 on the maintenance operations proper for the year 1938.

If to this figure of $5,173.76 is added that portion of an estimated $6,000 unexpended income or surplus, as listed in the budget, that was actually received as income, namely, $4,807.38, we have a total of $9,981.14; this last figure indicating the amount of budget allocation for current maintenance expenses that was not expended during the year. (These figures leave out of account, of course, the unforeseen or special expenses, to be discussed below, which were not foreseen, and therefore not included in the budget.)

* * *

The special or unforeseen expenses authorized by the Council during the year 1938-1939 may now be considered. These were unusually heavy and may be listed as follows:

1. New taxes not heretofore levied against the Association (Social Security, $540.98; Unemployment Reserve, $836.84; Sales Tax on CALIFORNIA AND WESTERN MEDICINE, $2,616.20), or a total of $3,994.02. (Note: Between December 31, 1938, and the date of the present report, March 28, 1939, additional taxation moneys have been paid out as follows: Social Security taxes, $42.10; Unemployment Reserve taxes, $209.43; total of both, $251.53).

2. State Humane Pound Act of November, 1938, State election (donation to California Society for Medical Research, $7,000; California Medical Association's separate campaign against the measure, $7,423.69); total, $14,423.69.

3. Settlement to the amount of $7,000 with Secretary Warnshuis, who retired on June 30, 1938. In the rearrangement of positions in the system now in operation there is an annual saving of $4,000 in the salary outlay through the consolidation of the duties of Secretary-Treasurer and Editor and Director of Public Relations.

(4) Special session of House of Delegates at Los Angeles to consider medical service plans, expenses being largely those of transportation and per diems of delegates, $3,459.54. (Between December 31, 1938, and the date of this report, March 28, 1939, the additional expenditure on this item has been $1,211.30; total on this item, $4,670.84.)

5. Legal expenses of State Association for studies and papers to lay the foundation for a medical service organization, $2,626.07 (prior to the incorporation of California Physicians' Service). (All in 1939.)

6. Announcements in advertising pages of Bay region newspapers at the opening of the State's Golden Gate International Exposition, $1,199.84 (paid in 1939). These items (1 to 6) for the year 1938, as just noted, make a total of $28,520.85, and for the year 1939, $15,443.88, making a grand total of $43,964.73.

To the above must be added two accessory items:

7. Cancer Exhibit in the Hall of Science of the Golden Gate Exposition, on which the sum of $2,500 has been paid. Of the ultimate total of $5,000 which will be needed for this exhibit, the sum of $2,714.16 has come from accumulated interest in the Morris Herzstein bequest, which may be used only for purposes outlined in the late Dr. Morris Herzstein's bequest. The difference between that amount and $5,000, namely, $2,285.84, will finally be repaid into the Association's administrative fund, when additional interest moneys come in from the Herzstein bequest, during the next several years.

Item 8, in the amount of $5,038.94, represents the first installment of an authorized loan to the amount of $15,000, which the House of Delegates, in special session at Los Angeles on December 18, 1938, authorized the Council to make to California Physicians' Service. Items 7 and 8 are not included, therefore, as actual charges against the main-

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* See CALIFORNIA AND WESTERN MEDICINE, November, 1930, pp. 829 and 833.

† See CALIFORNIA STATE JOURNAL OF MEDICINE, July, 1916, on page 260.

tenance income of the year 1938, for the reasons above noted, the Herzstein not being a part of maintenance income, and the California Physicians' Service item being a loan.

Before leaving the subject of finances, it is well to keep in mind that, during the coming year, a bank loan of $15,000 must be repaid.

If a basic science initiative is approved by the House of Delegates at Del Monte, the sum of something like $30,000 would be needed in 1939-1940 to secure the signatures and carry through the work.

Also to be remembered, is the authorization given by the House of Delegates at its special Los Angeles session in November, 1938, permitting the Council to loan to California Physicians' Service the sum of $15,000, of which sum $5,000 has been advanced.

It is possible that, in addition to the above, other expenditures to cover costs of educational literature on medical service and health insurance plans may be authorized.

II. Report of the Secretary

The central office of the California Medical Association is a busy place. The office personnel consists of five clerical assistants, who aid in routine correspondence, record filing, bookkeeping and accounts, Official Journal, and special duties as they may arise on activities such as the State Humane Pound Act, Medical Service plans, postgraduate schedules, House of Delegates' sessions and others of similar import.

Office Personnel.—The clerical aides, one of whom has been in the Association's service for more than twenty years, a second for eighteen years, a third for thirteen years, a fourth for two years, and a fifth for less than one year, have witnessed a heavy increase in the work as the membership has grown, and as the problems coming into the Central Office have become not only increasingly numerous, but more technical and demanding.

Similarly, as regards the space allotments of the office suite in the 450 Sutter building. The rooms were becoming more and more crowded with old records, so that ease in work was being prevented. Fortunately, the Four-Fifty Sutter Corporation, on our request, gave a half room on the same floor, without increase in rental. This addition, with institution of shelving, has provided space that makes possible a segregation of old records, with room also for occasional and current supplies and reserve stock.

Membership.—It may be of interest to glance at the total membership figures for the last twenty-five years. The totals given are those of December 1 of each year.

Year	*Members*	*Year*	*Members*
1916	2,602	1928	4,638
1917	2,699	1929	4,841
1918	2,534	1930	4,882
1919	2,496	1931	4,955
1920	3,126	1932	4,921
1921	3,445	1933	4,972
1922	3,666	1934	5,094
1923	3,809	1935	5,325
1924	3,945	1936	5,492
1925	4,138	1937	5,784
1926	4,326	1938	6,101
1927	4,449		

It is gratifying to know that the component societies have remained alert in their responsibilities in the matter of membership and that, in nearly all counties, efforts are constantly being made to bring into cordial affiliation and membership all eligible physicians. With impending legislation partaking of state medicine, it is possible that a considerable number of physicians who in the past, for various reasons, have remained somewhat aloof, may now find it to the liking of themselves and their fellows to align themselves as active workers in the ranks of organized medicine.

Component Societies.—For some years, the total number of county societies has been thirty-nine, although four of this number represent districts inclusive of ten counties; so that of the fifty-eight counties in California, a total of forty-five are represented in organized medicine. In explaining why some counties do not have societies, it should be remembered that in the "Forty-Niner" days, constitutional units of California in the northern section of the State were not infrequently established on the basis of mining population. Later, when the diggings lost productive output, the population likewise vanished. Thus, Alpine County, for example, covering some 776 square miles, has today a total population of only 241 persons. A county medical society in that county is naturally an impossibility.

To proceed further, there are, perhaps, only two remaining counties in the State where a conjoint component medical society may well be established; namely, in Inyo County (having an area of 9,991 square miles and a population of 6,555) and Mono County (having an area of 3,030 square miles and a population of 1,360). Much of the drainage basins of these two counties (which in the California Legislature are represented by a senatorial representative in the State Senate of forty members) is today owned by the City of Los Angeles, which draws much of its water supply from the Owens River Valley. On March 2, the Association Secretary, with officers of the Los Angeles County Medical Association, journeyed to the city of Bishop, in Inyo County, to aid in the organization of the Inyo-Mono Medical Society. The new organization will submit its petition for a charter as a component county society of the California Medical Association at the annual session to be held in Del Monte on May 1–4, 1939.

California and Western Medicine.—The peak years in advertising income for the Official Journal were 1928-1929. Then came a marked falling off, with gradual up and down improvement. The total advertising income in 1938 was $24,398.60, which, although considerably lower than in the peak years, compares well with that of other state medical publications, all of which have suffered comparative losses. In the last several months there have been indications of improvement.

Members of the Association are reminded that, if they will write to advertisers who have announcements in the Official Journal, for literature and samples, and mention the name of California and Western Medicine in making purchases (giving preference, other things being equal, to Official Journal advertisers), the income from advertising sources will undoubtedly show an increase. Through such coöperation, California and Western Medicine could become more nearly self-supporting. In helping advertisers in this manner, members would be helping the Association, because less money would then be needed from the general income fund for its support.

Incident to the formulation of medical service plans on a periodic payment basis, it was necessary to place at the disposal of members of the California Medical Association, much of the information that had influenced the House of Delegates and Council to organize the California Physicians' Service. Accordingly, the size of the Official Journal was increased by eight and sixteen page folios to meet this need. The extra expenditure seemed warranted under the circumstances.

Annual Session.—The report of the Committee on Scientific Work deals with the annual session program. It should not be out of place to remind members that the technical or commercial exhibitors at the annual session in Del Monte are worthy of the courteous interest of attending members; not only because of their displays, but also because here, likewise, coöperative appreciation by attending physicians will make for increased income for the Association. We bespeak for the exhibitors the kindly interest of all who will journey to Del Monte on May 1–4, 1939.

Scientific Exhibits.—Some comments, also, in regard to the section on Scientific Exhibits. An effort has been made to secure the registration of a large number of members to present scientific exhibits and medical films. If any members who would be interested in such displays have been overlooked, it is requested that they communicate promptly with the Central Office. Every effort will be made to arrange for placement.

Special Problems and Work:

During the last twelve months, the California Medical Association has been confronted with a larger number of special problems than usual. Among such may be mentioned:

State Humane Pound Act.—The story of the splendid victory over the antivivisectionists has been told in the OFFICIAL JOURNAL. The end-results were a tribute to the splendid coöperative endeavor of members of component county societies and the women's auxiliaries and other friends of medical research. It is regrettable that the battle should have drawn so heavily on the Association's funds, but the expenditure was unavoidable, because the issues at stake were of such vital nature. Thanks are extended to the many workers in all counties of the State, who gave such efficient aid in the distribution of literature and supplies sent out by the Central Office.

Medical Service Plans and the Special Session. The sustained interest during the last decade by the California Medical Association and its members on the important problem of distribution of medical service found expression in 1938 in a special session of the C. M. A. House of Delegates. Resulting therefrom came the formulation of a medical service based on a periodic payment basis, the principles of which had long been under consideration. Later, "California Physicians' Service" came into being. The story of the progress and activities of that organization, recently incorporated, has appeared in the OFFICIAL JOURNAL. The legal and other forms and all correspondence in relation to the new plan which had been accumulated in the Central Office were turned over to the California Physicians' Service when the latter organization established its headquarters in 602 Mills Building, San Francisco.

Postgraduate Work.—The plans for postgraduate work have received much attention and the groundwork has been laid for clinical conferences in many portions of the State, and allocation of topics, speakers, and dates are awaiting decision. This is a large work in itself, for it is not easy to arrange the times of guest speakers and physician audiences, so that the presentations may be made always with equal convenience for all concerned. To ask guest speakers to leave their private professional work for one or several days, and journey considerable distances, requires, in fairness, that the physicians of the communities to be visited shall likewise do their part. The transportation schedules of certain conference teams are now being studied. The coöperation of county societies is requested, so that in each place the experience with a clinical conference may be sufficiently favorable to lay the foundation for continued interest in graduate courses. Since the Association Secretary is also the secretary of the Committee on Postgraduate Activities, it will make for greater ease in outlining plans if all arrangements are made through the Central Office, 450 Sutter Street, San Francisco.

Department of Public Relations.—Because of the seriousness of major problems such as those above enumerated, the Department of Public Relations has not been as active during the last twelve months on matters of lesser policy. Plans are in the making, however, to bring back to the Department the consideration of problems and policies germain to its function.

Visitation Tours.—In the month of November, the Association Secretary accompanied President William W. Roblee on a visitation tour to county societies north of the Sacramento River, up to the Oregon line, and then down along the coast. Subsequently, in January, in company with President-elect Charles A. Dukes, a similar tour was made to the county societies located in the southern section of California, down to the Mexican border. And still later, in company with district councilors, most of the counties in the central portion of the State were visited. Naturally, everywhere, most of the conferences dealt with medical service plans. The visiting officers are deeply appreciative of the cordial manner in which they were received. There can be little doubt as to the value of this important field work, in making for harmonious outlook and unified effort by the medical profession of California.

In conclusion, the Association Secretary begs leave to express his personal appreciation of the kindly spirit extended him in assuming the responsibilities in the Central Office. There has been much work to do, but it has been pleasant to perform, and his thanks go to all who have aided him in the fulfillment of his duties.

Respectfully submitted,

George H. Kress, *Secretary-Treasurer.*

REPORT OF THE EDITOR

To the President and the House of Delegates:

The editor's report on papers received, printed, awaiting publication, or declined, is as follows:

(a) *Report on papers of the annual session at Pasadena, May 9–12, 1938:*

At last year's annual session a total of 144 papers were read before the general meetings and different sections.

A summary of the disposition of the papers read at that year's annual session is as follows:

Pasadena annual session papers published in 1938	17
Pasadena annual session papers published in 1939	18
Pasadena annual session papers read, but published elsewhere, declined or not sent in	87
Pasadena annual session papers in CALIFORNIA AND WESTERN MEDICINE files still awaiting publication (annual session papers in this April issue are not included)	22
Total annual session papers read at Pasadena	144

(b) *Report on special articles which have been printed in* CALIFORNIA AND WESTERN MEDICINE *during the period April, 1938 to April, 1939, inclusive:*

Special and original articles which were published in CALIFORNIA AND WESTERN MEDICINE during the past year (April, 1938 to April, 1939, inclusive) are as follows:

Section papers from annual session at Del Monte, 1937	57
Section papers from annual session at Pasadena, 1938	32
Papers read before general sessions at Pasadena, 1938	3
Lure of Medical History articles	16
Papers accepted from miscellaneous sources (original articles, abstracts of speeches, reprints from other publications, etc.)	35
Clinical Notes and Case Reports	40
Editorials	57
Editorial Comment articles	30
Bedside Medicine symposia	12
Special articles	78
Total papers published during past year	360

(c) *Report on manuscripts in* CALIFORNIA AND WESTERN MEDICINE *files and awaiting publication in April, 1939, and later issues:*

Unpublished papers from annual session at Pasadena	22
Unpublished papers accepted from miscellaneous sources	8
Lure of Medical History articles	5
Clinical Notes and Case Reports	17
Editorial Comment articles	7
Bedside Medicine symposia	2
Total manuscripts on hand, awaiting publication	61

(d) *Report on nonannual session papers submitted:*

Nonannual session papers submitted, but declined	52

Comment.—During recent years CALIFORNIA AND WESTERN MEDICINE, as the OFFICIAL JOURNAL of the California Medical Association, has undergone comparatively few changes in format. Its arrangement of departments and type forms has been designed to promote ease and comfort in perusal, as well as convenience in ready reference; for the day is past when busy physicians can give time to any publication, the reading of which makes for avoidable effort. This desideratum applies to the printed word everywhere, be it the presentation of the subject matter discussed, good or poor, scientific or of other nature.

A new feature introduced during the last year is "Press Clippings," a subdepartment of "News." This was instituted because it is important for members of the Association to know the reaction of the press on proposed health legislation and the plans of the California Medical Association, as embodied in California Physicians' Service. Also on other medical problems and policies, such as county hospitals and the medical care of migrants.

Papers read at the annual sessions of the State Association naturally have priority in consideration. The basic rules of the Council continue to obtain, however, namely, that, inasmuch as the majority of members of the State Association are general practitioners, articles of interest to this larger group of physicians are more apt to be accepted for publication than discourses on technical or rarer subjects, or topics which might more favorably be placed in specialty journals.

The California Medical Association is the expression of organized medicine in the state, and in times such as the present, when fundamentals in economic, social welfare and political activities are all under strain, it is only reasonable that a large portion of the pages of the OFFICIAL JOURNAL should be devoted to information of importance to physicians; even though seemingly far distant from the field of abstract discussion on scientific matters. Consequently, the thought has been constantly kept in mind that word pictures, as true as possible, should each month be so given that all members of the Association, be they in either urban or rural practice, might be able to orient themselves concerning trends, both in scientific and organized medicine, and so visualize not only impending influences of the moment, but also those that are apt to arise in either the near or remote future.

Under instructions from the Council, the officers and members of the House of Delegates of the American Medical Association—supreme parent group of organized medicine in the United States—are on the complimentary mailing list. California's problems are thus regularly brought to the immediate attention of medical leaders in every state in the Union; and it has been gratifying to receive words of commendation for CALIFORNIA AND WESTERN MEDICINE from so many of these colleagues, far distant and in practice under conditions quite different from those that obtain on the Pacific Coast.

Whatever editorial regret exists rests chiefly upon the fact that so large a number of excellent annual session papers must be released each year for publication in other journals. With a membership in excess of six thousand, and the many contributions available and pressing from the programs of both the State Association and its component county societies, there is, however, no other choice. Members who read papers, therefore, howsoever meritorious, are reminded that condensed presentations, if submitted for consideration and possible publication, have a much better chance of acceptance than lengthy articles, coupled often with an excess of expensive tabular matter or illustrations.

The Editor desires to thank the many members who have thus submitted original articles and other contributions, and to express his appreciation to all who, when called upon for special service, have so generously given aid to the OFFICIAL JOURNAL. For this and other reasons, it has been a genuine pleasure to continue to function as editor of CALIFORNIA AND WESTERN MEDICINE.

Respectfully submitted,

George H. Kress, *Editor*.

REPORT OF THE LEGAL DEPARTMENT

To the President and the House of Delegates:

Each year finds the medical profession, as such, subjected to more and more pressure and increasingly violent assaults from organized minorities of one type or another. Of late, certain special interest groups have seemingly acquired a measure of control over government, so that the profession may in the future be faced with governmental intrusion in addition to the activities of private groups. As may be expected, each additional controversy involving the medical profession necessarily increases and extends the duties and labors to be performed by your attorney and his staff.

For the past several years, the report of the legal departmen has shown an increase in the volume of legal work undertaken on behalf of the Association. This year it is necessary, once again, to state that the activities of the legal department are necessarily on the increase.

We will endeavor to review the past year's work as briefly as possible, and at the same time we hope to convey an accurate picture of the various questions referred, and the duties performed.

Corporate Practice.—This department's reports for the past several years have contained paragraphs devoted to the subject of corporate practice. Last year we reported that there was then pending before the California Supreme Court an action entitled: "People of the State of California on the relation of the Board of Medical Examiners vs. Pacific Health Corporation," and that the action involved the right or lack of right of the Pacific Health Corporation (a stock corporation organized for profit) to furnish the services of a selected panel of physicians to its policyholders. We also reported that, at the direction of the Council, we had prepared written briefs in support of the position of the Attorney-General, which was that the Pacific Health Corporation was unlawfully engaged in the corporate practice of medicine. In September, 1938, the California Supreme Court, by a 4-3 decision, decided that the Pacific Health Corporation was engaged in the corporate practice of medicine and that such practice was unlawful. The four justices were of the opinion that the position of the Attorney-General and this office was correct, and they also were apparently of the opinion that a nonprofit corporation defraying the costs of medical service on a periodic payment basis, and not restricting patients' freedom of choice of physician, would not be engaged in the corporate practice of medicine. This decision of the California Supreme Court is of the utmost significance because California Physicians' Service, which was formed pursuant to the direction of the House of Delegates at its special meeting in December, 1938, is a nonprofit corporation providing complete freedom of choice of physician and undertaking to defray the costs of medical care on a periodic payment basis.

After the decision of the California Supreme Court, Pacific Health Corporation petitioned the Supreme Court of the United States for a writ of certiorari. However, the United States Supreme Court recently denied the writ, so that at the present time the decision of the California court is final and conclusive.

County Hospitals.—In May, 1938, the Chairman of the Council appointed a committee, of which Dr. Henry A. Rogers is chairman, to confer with representatives of the various farm groups in this state for the purpose of reaching a solution to the apparent differences of opinion which seemed to exist between the medical profession and farm organizations. Doctors Rogers, Packard, Anderson and Emmons arranged and held several conferences with farm organization representatives and your general counsel; and Mr. Hassard, one of his associates, attended each of them. Many legal problems have arisen in connection with this subject, and a great deal of time has necessarily been spent by the committee and the legal department in their consideration. The satisfactory progress made in this effort to solve the county hospital and other related problems will, no doubt, be reported by Doctor Rogers for the Committee on Farm Organization Conferences, and by Doctor Packard for the Committee on County Hospitals.

Workmen's Compensation Case.—This department's report for the year 1937 contained a résumé of our activities in the case of "Pacific Employers Insurance Company vs. Industrial Accident Commission and Kenneth Tator." At that time we reported that, in the direction of the Council, your general counsel and Mr. Hassard appeared before the California Supreme Court on behalf of several physicians who had rendered professional services to an injured employee, employed in Massachusetts, but injured in California, and whose right to receive compensation in California ws being questioned. We also reported that the California Supreme Court had decided in favor of the injured employee and the physicians; that is, the Supreme Court had decided that compensation was payable in California. Subsequent to our last report, the insurance company involved has appealed to the Supreme Court of the United States. The case was argued orally before the United States Supreme Court by Attorney Frank J. Creede, representing Mr. Tator, and Attorney Everett Corten, representing the Industrial Accident Commission of California, in December, 1938. The case has been fully briefed and is now awaiting decision by the United States Supreme Court.

Engelking vs. Carlson (Res Ipsa Loquitur Case).—In this case the question of law involved is substantially as follows: Is there an inference of negligence which is evidence in favor of the plaintiff in every malpractice action involving an alleged injury received during the course of a major surgical operation? The trial court decided that there was no such inference of negligence, but on appeal the District Court of Appeal held otherwise. Immediately after the decision of the District Court of Appeal, acting pursuant to the direction of the Council, we joined with the attorneys for the defendant physician in an effort to secure a hearing before the Supreme Court of California. A petition for a hearing was prepared and filed, and your general counsel and Mr. Hassard prepared a brief as amici curiae in support of the petition for hearing and presented it to the Supreme Court. The petition was granted and the case was transferred to the Supreme Court, thus automatically terminating the opinion of the District Court of Appeal. The case was orally argued before the Supreme Court late in 1938, your general counsel appearing in court on behalf of the defendant physician (at the request of counsel for the physician). The case is now under submission and a decision may be expected in the near future. This case is of vital importance to all surgeons and to the medical profession generally, because, if it is decided against the defendant, it will further increase the scope of the doctrine of res ipsa loquitur and thereby place a terrific burden and, in our opinion, an unjust responsibility upon all physicians and surgeons undertaking to perform surgical operations.

Osteopathic Cases.—During the past year several problems have arisen with respect to the rights and privileges of osteopaths and osteopathic physicians and surgeons. At the direction of the Council, the legal department has rendered opinions and suggestions to several county societies on this subject. Without going into detail, one typical example may be mentioned. An osteopathic physician and surgeon practicing in a California community contended that he had a legal right to practice in a hospital operated in the community by the municipality, and he threatened to bring suit against the city authorities unless he was permitted to send his patients to the hospital and practice therein. The county medical society requested our assistance, and, after an examination of various decisions throughout the United States, we submitted a written opinion which the county medical society in turn submitted to the city attorney. In our opinion we reviewed cases arising in other states in which it has been held that an osteopath or an osteopathic physician and surgeon may be denied the privileges of public and private hospitals if the hospitals so desire. After this opinion was furnished to the city attorney and to the attorney for the osteopathic physician and surgeon, all threats to sue were discontinued.

Another matter which should be mentioned is the case of *Jordt* vs. *State Board of Education*, which is now pending before the Superior Court in Sacramento. In this action an osteopathic physician and surgeon is suing the State Board of Education for the purpose of requiring it to grant to him a health and development certificate, so that he may qualify as a school physician under the California School Code. At the request of the Attorney-General and at the direction of the Council, this office has kept in touch with the case and has submitted several briefs and memoranda of authority to the Attorney-General's office. The Attorney-General, who represents the State Board of Education, demurred to the complaint, but the demurrer was recently overruled and the case is now ready for trial.

The Humane Pound Initiative.—The Humane Pound Initiative, which was decisively defeated at the last general election in November, 1938, occasioned considerable activity on the part of the legal department. At the direction of the Council, we analyzed each of the terms and provisions of the Humane Pound Initiative and prepared an opinion on its legal features, which was forwarded to the Society for the Promotion of Medical Research. From time to time, at the request of various county medical societies and individual physicians, we further analyzed the initiative, and prepared and submitted various explanatory opinions with respect to its provisions. In addition, your general counsel and his associates did everything in their power to aid in the defeat of the measure.

San Francisco City Employees' Health Insurance System.—In April, 1938, after the Health Service Board of the San Francisco City Employees had adopted a plan for the rendering of medical care, the City and County Controller refused to pay over salary deductions to the Board until the legality of the charter amendment creating a health service system had been finally determined. Thereupon, the Health Service Board commenced a mandamus proceeding in the Supreme Court entitled *"Butterworth* vs. *Boyd."* At the direction of the Council, the legal department followed closely the progress of this case without appearing therein on behalf of any of the parties thereto or as friends of the Court. From time to time reports were made to the Councilors and officers of the Association with respect to the status of the case; and when the Supreme Court, in September, 1938, decided that the charter amendment was constitutional and enforceable, an analysis of the Court's opinion was prepared and furnished to the Association.

Taxation.—For many years the California Medical Association, being a nonprofit, scientific and educational association of doctors of medicine, has been held exempt from most of the great number of taxes levied by Federal, State and local governments. In the past few years many new taxes have been added by Federal and State governments, and there has been a definite tendency to eliminate tax exemptions.

On September 9, 1938, the Commissioner of Internal Revenue of the United States, by a formal ruling, revoked the exemption granted to the California Medical Association many years ago from income, capital stock and excess profit taxes. The existing exemption was based on the fact that the California Medical Association is a nonprofit organization devoted to scientific and educational purposes. The Commissioner, in revoking the prior ruling, stated that the Bureau of Internal Revenue had changed its mind, and no longer considered the California Medical Association to be a scientific and educational organization. A new ruling was immediately issued granting the California Medical Association exemption from income, capital stock and excess profit taxes on the ground that the Association is a "business league." The net effect of this ruling was to leave the Association's exemption from income, capital stock and excess profit taxes undisturbed, but for the first time to subject the Association to Social Security taxes, both Federal and State.

After reviewing authorities and considering all of the surrounding circumstances, the legal department recommended to the Council that it acquiesce in the new ruling of the Commission of Internal Revenue and commence payment of Social Security taxes under Title VIII of the Social Security Act and under the California Unemployment Reserves Act.

In October, 1938, both the Federal and State governments for the first time contended that the California Medical Association was liable for Social Security taxes not only from and after the date of the business league ruling, but also for the years 1936, 1937 and the first nine months of 1938. That is to say, a retroactive effect was sought to be given to the business league ruling. This decision was immediately disputed and a formal protest was submitted to the Commissioner of Internal Revenue.

On March 13, 1939, the legal department was informed that the Treasury Department has decided that the Association must pay a tax plus penalties for the period during which the Department's prior ruling granting an exemption was in full force and effect. Needless to say, this decision is considered erroneous.

Various written documents, including protests, briefs and memoranda, have been prepared, and a number of hearings have been held before Treasury Department officials.

In addition, both the Federal and State governments are now contending that all officers of the California Medical Association, including Councilors and committee chairmen, are the "employees" and subject to payroll taxes. In our opinion, this view is contrary to the law and we are, on behalf of the Association, protesting the departmental rulings.

Malpractice Insurance.—During the past year the legal department has at all times been available to those members of the Association who have desired information and advice with respect to the legal form and legal effect of malpractice insurance policies. A great many members have availed themselves of the services of this department in this regard, so that during the year many opinions have been prepared and submitted on the subject of malpractice insurance. In addition, the legal department keeps in touch with the various surplus line brokers representing Lloyd's underwriters and the American companies in this field, in order to protect and guard the interests of the medical profession.

Medical Service Plan.—Since October, 1938, most of the time of your general counsel and his associate, Mr. Hassard, has been devoted, first, to assisting the special committee of the Council appointed to prepare a medical service plan, and second, after the action of the House of Delegates in Los Angeles, December 18, 1938, to the handling and solution of the multitude of legal problems involved in incorporating and organizing California Physicians' Service. Pursuant to the direction of the Council, the legal department has at all times been available to those officers and members of the Association who have been charged with the duty of effectuating the medical service plan, and since the organization of California Physicians' Service the legal department has carried out all instructions received from the board of trustees of that organization. The immense amount of work involved in formulating a medical service plan on a voluntary monthly prepayment basis can, perhaps, be best expressed by stating that the preparation of the various documents furnished the House of Delegates at its special meeting in Los Angeles constituted only a small portion of the necessary research and labor undertaken.

Legislation.—At the direction of the Council, the legal department has prepared several bills for introduction to the Legislature and, in addition, has prepared amendments to a number of bills introduced by other organizations and groups. Your general counsel and his associate have attended each meeting of the Committee on Public Policy and Legislation, and have at all times endeavored to assist the committee to carrying out its arduous and difficult duties. Over two hundred bills have been analyzed for the committee, so that the Association and its members may be informed with respect to the nature of all legislation relating to the field of medicine now under consideration by the California Legislature. In addition, various memoranda and opinions have been prepared and submitted to the Committee on Public Policy and Legislation regarding pending legislative measures.

Miscellaneous.—During the past year opinions have been requested and furnished dealing with such subjects as disciplinary procedure, the extent of the power of the Medical Society over admissions to membership, legal and ethical aspects of group medical practice, the power of cities to impose license taxes on physicians, the legal effect of medical and hospital indemnity insurance policies, the extent of the power of hospitals to regulate those who may practice therein, and many other things.

An article for the Medical Jurisprudence column in CALIFORNIA AND WESTERN MEDICINE has been prepared each month.

Attendance at conferences of officers, at meetings of the Council, Executive Committee and other standing and special committees, and with the members of a number of county societies where matters of great interest to the medical profession have been considered, has been maintained throughout the year.

It may be proper to state that these matters, covering as they do a wide range of activities, the services of associates of general counsel other than Mr. Howard Hassard, have been found necessary and helpful in the interests of the Association.

Respectfully submitted,
Hartley F. Peart, *General Counsel.*

II

REPORTS OF DISTRICT COUNCILORS

FIRST COUNCILOR DISTRICT

Imperial, Orange, Riverside, San Bernardino, and San Diego Counties

To the President and the House of Delegates:

Our secretary-editor has called for the councilor reports from the nine councilor districts for publication in the Pre-Convention Bulletin of CALIFORNIA AND WESTERN MEDICINE.

Another year has rolled around and medical affairs have seen little change in the "big First District." There has been a noted increase in membership in each of the county societies. Voluntary prepaid hospital service has been purchased by a small number here and there, but the general desire has been for a complete prepaid service.

The county societies in the First District have been visited several times, and once with President-Elect Charles A. Dukes and Secretary-Editor George H. Kress. These men were greeted by large groups, who eagerly listened to the latest word about the California Physicians' Service. None of us wish a change in the present medical relationship, as it now exists, between the doctor and his patient, and none wish to see our profession exploited by an organized group of politicians working under some compulsory plan. It looks as if California was about to be the testing ground. Well, the doctors of medicine of this state are not going to be found unprepared, but will be a united group of over six thousand individuals opposing their regimentation under any other leadership than medical. If group practice must come, let it be medically controlled and directed under a voluntary plan where the patient can select the physician of his choice among those who hold a doctor of medicine license in the State of California.

Respectfully submitted,

Calvert L. Emmons, *Councilor,*
First District.

SECOND COUNCILOR DISTRICT

Los Angeles County

To the President and the House of Delegates:

Decided progress has been made in adding to the membership roll this year, a total net gain of 206 having been recorded.

The parent organization and the various sections and branches have been very active along both scientific and medical economic lines.

With the advent of the California Physicians' Service there has been a marked stimulus to interest in organization and allied matters. The sentiment seems to be overwhelmingly in favor of the plan, and there is no doubt that it will receive enthusiastic support.

Respectfully submitted,

Carl R. Howson, *Councilor,*
Second District.

THIRD COUNCILOR DISTRICT

Kern, San Luis Obispo, Santa Barbara, and Ventura Counties

To the President and the House of Delegates:

As councilor of the Third District, all of the societies were visited with Dr. Charles Dukes, president-elect, and Dr. George Kress, secretary of the California Medical Association. The meetings this year were exceptionally well attended and enthusiastic. In addition to the regular county meetings, Doctors Dukes and Kress and the councilor met with the Santa Maria group, in the northern end of Santa Barbara County, and were entertained there by about twenty members who had been unable to attend the evening before at Santa Barbara.

All the counties in the district have shown a healthy growth, and unusual enthusiasm has been manifested in the important affairs of the California Medical Association. The officers of the component societies have been especially alert and coöperative, and it is apparent that the members of the C. M. A. in the Third District are more alive to the needs and necessities of medicine today than they ever have been before.

Following an exceptionally well put on two-day postgraduate conference in March, 1938, at which more than one hundred registered from the district, the conference was repeated this year along the same lines which were so successful in 1938. It is hoped to make the Santa Barbara conference second to none in the State, and, with the support that has been afforded it and the experience gained in the past two years, it is felt that Santa Barbara can surpass all efforts in 1940.

The coöperation of the Secretary's office and all other State officials is appreciated by all the members of the Third District.

Respectfully submitted,

Louis A. Packard, *Councilor,*
Third District.

FOURTH COUNCILOR DISTRICT

Fresno, Madera, Kings, Tulare, Merced, Mono, Mariposa, Inyo, Calaveras, San Joaquin, Tuolumne and Stanislaus Counties

To the President and the House of Delegates:

A lively interest in the development of California Physicians' Service has been shown throughout the district. Hearty coöperation in establishing the C. P. S. as a going concern may be expected. The defeat of the antivivisection initiative last November was a gratifying demonstration of united action on the part of the profession, pharmacists, nurses, et cetera. Local activity was enthusiastic. Much of value for future contests for the protection of public health was learned.

The San Joaquin County Society, under the leadership of Dr. Charles A. Broaddus, is showing the State what can be done about postgraduate work at home. The plan employed has been commended by the councilor to all other societies in the district.

The councilor has, during the year, visited all societies in the district and has found a ready willingness to coöperate in C. M. A. activities everywhere. The membership is steadily increasing, and society activities, in most instances, are satisfactory. One new county society was recently organized in this district, comprising Inyo and Mono counties. Some change in the councilor district to avoid a trip of almost 1,000 miles to visit this society may be wise.

Service by this councilor on the County Hospital Committee has included conferences with farm organizations and other members of the committee for the development of acceptable changes in the existing laws governing county hospitals, and he believes that, if pending legislation be adopted, it will greatly improve present management of such institutions, benefit the public concerned, and prove of value to the profession.

Respectfully submitted,

A. E. Anderson, *Councilor,*
Fourth District.

FIFTH COUNCILOR DISTRICT

Monterey, San Benito, San Mateo, Santa Clara, and Santa Cruz Counties

To the President and the House of Delegates:

Increasing interest and activity in the problems of the cost of medical care has been manifest in the Fifth District during the past year.

A joint dinner meeting between the Santa Clara County and San Mateo County societies was held at Agnew State Hospital and addressed by President W. W. Roblee and Secretary George H. Kress. A similar joint meeting between Monterey County and Santa Cruz County at Del Monte gave all members in the district an opportunity of becoming better acquainted with our officers.

Monterey County Society is planning to demonstrate their usual hospitality at the annual meeting this year.

Respectfully submitted,

Alfred L. Phillips, *Councilor,*
Fifth District.

SIXTH COUNCILOR DISTRICT

San Francisco County

To the President and the House of Delegates:

The past year has been remarkable for the interest shown by the members of the Sixth District in the attempt of the California Medical Association to build a successful organization through which the cost of sickness can be met by periodic payments.

Our members feel that this has been accomplished through the formation of the California Physicians' Service, and they are united in the determination to do all within their power to help bring success to the new venture.

The usual "county society" problems have been met as a matter more or less of routine. We feel that our strength in unity has grown with the number of our members, which is now the greatest that it has ever been.

Respectfully submitted,
Karl L. Schaupp, *Councilor,*
Sixth District.

SEVENTH COUNCILOR DISTRICT

Alameda and Contra Costa Counties

To the President and the House of Delegates:

The Seventh District, comprising the counties of Alameda and Contra Costa, has shown a favorable condition during the past year.

Alameda County Medical Association has held ten regular meetings, the programs for which were presented in large part by the members of the Association. Three guest speakers appeared before the Association and, in conjunction with the Oakland Forum, a special luncheon meeting honoring Dr. Morris Fishbein, editor of the *Journal of the American Medical Association,* was held.

There has been a steady increase in the growth of the Alameda County Medical Association, forty-five members having been added during the year. Through resignation, death and delinquency of dues, twenty-five members were lost. This leaves an actual net gain of twenty-five members.

The Association has coöperated with city and State health authorities in the establishment of adequate venereal disease clinics, and other matters of public health interest.

The Association of Approved Hospitals has expanded its interests to include a number of neighboring counties.

Alameda County Medical Society notes with pride that 100 per cent of its members were members of the Society for the Promotion of Medical Research, and aided in the defeat of the proposed Humane Pound Act. It is likewise proud of its library, which, in coöperation with Lane Library, is able to bring medical publications to its members.

The Contra Costa County Medical Society has held ten meetings during the year.

There has been an increase in the membership of the Society.

The value of Woman's Auxiliaries in county societies has been demonstrated in Contra Costa County Medical Society during the recent campaign to protect medical research, when the Auxiliary members offered unremitting and effective aid.

Respectfully submitted,
O. D. Hamlin, *Councilor,*
Seventh District.

EIGHTH COUNCILOR DISTRICT

Alpine, Amador, Butte, Colusa, Eldorado, Glenn, Lassen, Modoc, Nevada, Placer, Plumas, Sacramento, Shasta, Sierra, Sutter Tehama, Yolo, and Yuba Counties

To the President and the House of Delegates:

During the past year, visits were made to the various societies in the Eighth District, where meetings were well attended and programs of scientific and practical interest were presented. The members of these societies were found to have a wide and accurate knowledge of medical problems, and were interested in finding ways and means to solve these problems.

With President Roblee and Secretary Kress, official visits were made later in the year, the meetings being well attended and satisfactory.

Respectfully submitted,
F. N. Scatena, *Councilor,*
Eighth District.

NINTH COUNCILOR DISTRICT

Del Norte, Humboldt, Mendocino-Lake, Marin, Napa, Solano, Sonoma and Trinity Counties

To the President and the House of Delegates:

The past year has been a very busy one, as the medical society activities in the ninth district have been on the decided increase.

The Solano County Society held its annual meeting in Vallejo on July 16, entertaining President W. W. Roblee, President-elect Charles Dukes and Secretary-Editor George Kress. This meeting attracted, as usual, medical men from all adjacent county societies.

In May, September, November and December, joint conferences with farm leaders were arranged and held in San Francisco, helping to create a mutual understanding of rural medical needs.

Napa County again held its annual joint meeting with the dentists and attorneys. At the joint meeting with the lawyers, when Mr. Peart was one of the main speakers of the evening, the superior judges, district attorneys and legislators from most of the adjoining counties were present.

The Napa County Annual Jinks Party, held at the Napa Country Club on December 10, was attended by 135, physicians and visitors being present from the entire North Bay area and San Francisco. Dr. Lloyd Kindall's Medical-Dental Band again furnished the main entertainment of the evening. Governor Merriam and several legislators also were present as guests and speakers. These joint meetings should be held by every county medical society in the State, as they help to bring about a better understanding of mutual problems.

In January a district meeting was held at Sonoma to discuss the California Physicians' Service. Every county in the Ninth District was represented, and the action of the special meeting of the House of Delegates held in Los Angeles was freely explained and discussed.

On November 6, 7, and 8, I accompanied President Roblee and Secretary Kress on their trip to the northern counties, holding meetings at Yreka and Eureka, and visiting with doctors at Crescent City and Ukiah. At Ukiah, Doctor Cushman and staff entertained us with a dinner in his house at Talmage. On this trip we inspected, by invitation, the hospital erected at Shasta Dam site, the County Hospital at Yreka and some of the wards at Talmage.

During the year I have made councilor calls upon all of the medical societies in the Ninth District. Several societies have been visited many times. I have attended all councilor and council committee meetings of which I was a member.

Again let me say that, although it has been a very busy year, I have enjoyed to the fullest extent every bit of it.

Respectfully submitted,
Henry S. Rogers, *Councilor,*
Ninth District.

III

REPORTS OF COUNCILORS-AT-LARGE

To the President and the House of Delegates:

This brief report marks another year of effort to lend aid to the members of the medical profession, their individual and organization activities, in advancing the standards of practice and protecting the mutual interests of the people as a whole and the profession.

Many meetings have been attended and important and routine matters deliberated and either settled temporarily or carried on for further consideration until circumstances permitted the adoption of a more mature opinion.

We have started the California Physicians' Service and are working with the hospital service organizations. We are about seven years too late to be effective, but nevertheless should constantly bend every effort to work together in our community interests, which is the philosophy that sustains all of us, irrespective of conditions and actions that may or may not coincide with our personal opinions.

Respectfully submitted,
Harry H. Wilson, *Councilor-at-Large.*

To the President and the House of Delegates:

The main activities of the San Diego area during the past year were those having to do with the election. Not only did we do our bit to defeat the "Humane Pound Act," but we also won out in the local supervisorial race. By so doing we were able to continue the prestige of our County Hospital Committee, which provides a very satisfactory set-up in this county for the care of the indigent sick.

Respectfully submitted,
C. O. Tanner, *Councilor-at-Large.*

To the President and the House of Delegates:

Observation shows both a marked increase on the part of the membership of the California Medical Association in knowledge of and of interest in the important matters now confronting the medical profession.

The question of compulsory or voluntary health insurance is now most important. It still remains for the membership to respond without delay to demands for action by those to whom we entrust our destinies; for there seems to be a determined effort on the part of several factions to regulate the practice of medicine.

Respectfully submitted,
W. H. Kiger, *Councilor-at-Large.*

To the President and the House of Delegates:

As a Councilor-at-large of the Association, I have participated in a number of meetings of the Council and served as a member of the committee which formulated the plan for California Physicians' Service.

The results of these activities are matters of record.

Respectfully submitted,
T. Henshaw Kelly, M.D.,
Councilor-at-large.

To the President and the House of Delegates:

In years during which the Legislature is in session your councilor-at-large must give extra time to the work of the Committee on Public Policy and Legislation. However, he has joined with the Association officers in their visitations to the district in which he is located and has endeavored to be of aid whenever possible.

Respectfully submitted,
Junius B. Harris, *Councilor-at-Large.*

To the President and the House of Delegates:

During the past year considerable time was spent by your Councilor-at-large at committee meetings dealing with questions concerning certain activities relating to the Golden Gate International Exposition.

Still more time was devoted, as chairman, to your Special Committee on Animal Experimentation. This committee was specially concerned with the defeat of the so-called "Humane Pound Bill," an antivivisection measure submitted to the voters at the general election in November, 1938. The chairman was authorized as the committee's representative on the Executive Committee of the California Society for the Promotion of Medical Research, organized in 1915 by medical, educational and business leaders throughout the State, to promote medical research and combat attacks and legislation tending to restrict it. During the year your Councilor-at-large served as chairman of the Campaign Committee of this latter organization.

Considerable time has also been devoted to the work of our San Francisco County Committee on malpractice insurance.

Respectfully submitted,
Philip K. Gilman, *Councilor-at-Large.*

IV

REPORTS OF STANDING COMMITTEES

EXECUTIVE COMMITTEE

T. Henshaw Kelly, Chairman
William W. Roblee, President.
Charles A. Dukes, President-elect.
Howard Morrow, Past President.
Lowell S. Goin, Speaker, House of Delegates.
Karl L. Schaupp, Chairman of the Council.
T. Henshaw Kelly, Chairman, Auditing Committee.
George G. Reinle, Chairman, Committee on Public Relations.
George H. Kress, Secretary-Treasurer—Editor.

To the President and the House of Delegates:

The Executive Committee has had only one meeting this year, the business of the Association having required a sufficient number of Council meetings to make further meetings of the Executive Committee unnecessary.

The minutes of the Executive Committee are incorporated in the Council minutes.

Respectfully submitted,
T. Henshaw Kelly, M.D., *Chairman.*

AUDITING COMMITTEE

Executive Group

T. Henshaw Kelly, Chairman, 1939
O. D. Hamlin, 1939
Philip K. Gilman, 1939

To the President and the House of Delegates:

The Auditing Committee has conducted its usual duties during the past year and the Auditor's report of the status of finances, which is the main part of this report, is kept on file in the offices of the Association and will be filed at the Association desk during the meeting at Del Monte.

Respectfully submitted,
T. Henshaw Kelly, M.D., *Chairman.*

COMMITTEE ON ASSOCIATED SOCIETIES AND TECHNICAL GROUPS

Executive Group

John V. Barrow, Chairman, 1940
Edwin L. Bruck, 1941
W. H. Geistweit, 1939

To the President and the House of Delegates:

The Committee on Associated Societies and Technical groups begs to submit its usual report along the line of its usual activities.

Reports from Dr. W. H. Geistweit, Jr., of San Diego, and Dr. Edwin L. Bruck of San Francisco, coincide with my own activities in aiding the Auxiliary in an advisory capacity at various times.

We had under plans the listing of the voting capacity of physicians and patients if and when called upon by the State Council or the Committee on Legislation. The essential need of this work was forestalled by other methods of handling the voting campaign in the last election, and is practically always provided for by the Committee on Public Relations and other committees of the Association.

Each of us has contacted the nursing organizations of our communities, and Doctor Geistweit has rendered very valuable service with the nurses in his district, in particular in consideration of their proposed legislation aiming at a separate nursing board. The opposition encountered from certain other committees in this matter suggests again a closer relation between our committee and other committees when matters concerning one of our groups are being considered.

We regret the failure of coördinating efforts between the Nursing Association and the State Medical Association before the Nurses' Association began formulating its bill. However, our feeble efforts to forestall this situation were unavailing, although Doctor Geistweit was particularly active in his section in trying to arrive at a better understanding.

We respectfully request the approval of the Council in the promulgation of conjoint meetings all over the State among local societies of each associated organization. We would like to be able to find out the plans of these associations and technical groups before any action is taken by them in matters of mutual interest.

In our doing this we do not wish to be thought to supplant the work of any other committees of the Association. Our findings will serve only for the information of the State Council, to which they will be submitted as early as possible.

Respectfully submitted,
John V. Barrow, *Chairman.*

COMMITTEE ON HEALTH AND PUBLIC INSTRUCTION

Executive Group

Fred B. Clarke, Chairman, 1941
W. R. P. Clark, 1939 Benjamin W. Black, 1940

To the President and the House of Delegates:

The most important work that this committee has done this year was to appoint, at the suggestion of the Council, a subcommittee on "Pneumonia Control."

The personnel of this committee is as follows: Roy E. Thomas, chairman, Los Angeles; Lambert B. Coblentz, San Francisco; Edwin L. Bruck, San Francisco; Karl F. Meyer, San Francisco; William P. Shephard, San Francisco; George D. Maner, Los Angeles, and Daniel B. Comstock, Los Angeles.

The purpose of this committee is to familiarize the doctors of California as to the latest methods of treating pneumonia.

The committee has urged the development of the Speakers' Bureau in the larger county units of the State, with the expectation that they can contribute to the education of the public in matters relating to health.

Respectfully submitted,
Fred B. Clarke, *Chairman.*

COMMITTEE ON HISTORY AND OBITUARIES

Executive Group

Frank R. Makinson, Chairman, 1941
A. Elmer Belt, 1940 J. Marion Read, 1939
The Secretary, ex-officio The Editor, ex-officio

To the President and the House of Delegates:

Your Committee on History and Obituaries is pleased to report that its work is progressing slowly, but continuously; however, committee meetings have not been part of the star performance.

The biographical data blanks have been sent out and we trust that everyone will avail himself of the opportunity to assist the committee in its work by filling out the blanks completely, and returning them to the headquarters of the Association.

It is felt that one accomplishment is of special interest, namely, a portrait of Benjamin Franklin Keene. This was found in Georgia, and permission has been obtained to photograph it. Doctor Keene was president of the California Medical Association, having served during the year 1856.

It is recommended that five hundred dollars be allotted and ear-marked for the use of this committee in purchasing old journals, books, and other archives pertaining to the history of our Association.

Seventy-three of our members passed to their great reward during 1938. May their souls rest in peace! The entire list of names appears in the Supplement to CALIFORNIA AND WESTERN MEDICINE bearing the date of March, 1939. It seems only fitting that three names should be especially mentioned: those of Emmet Rixford of San Francisco, Joseph P. Widney of Los Angeles, and Joseph M. King of Los Angeles, who served as our president in 1932.

Respectfully submitted,
Frank R. Makinson, *Chairman.*

* * *

IN MEMORIAM

Abraham, Vestal Raul, October 10, 1938, Long Beach.
Baker, Fred, May 16, 1938, Point Loma.
Bishop, Thomas W., December 28, 1938, Pasadena.
Bliss, Walter Parks, November 3, 1938, Pasadena.
Blond, Harry Hyman, March 11, 1938, Los Angeles.
Bowers, Paul E., February 15, 1938, Los Angeles.
Brinckerhoff, Elmer Ellsworth, March 12, 1938, Oakland.
Carpenter, Frank L., May 16, 1938, Berkeley.
Clark, Edward Perry, September 5, 1938, Los Angeles.
Crabtree, Winston Churchill, July 14, 1938, San Diego.
Dickerson, Harry William, March 24, 1938, San Diego.
Dillon, Edward Thomas, October 14, 1938, Los Angeles.
Dundas, Robert C., November 20, 1938, Los Angeles.
Fitzpatrick, Earl Berton, December 11, 1938, Martinez.
Frederick, Marcus White, September 4, 1938, Brentwood.
Freund, E., December 13, 1938, Los Angeles.
Galbraith, George H., September 11, 1938, Long Beach.
Gates, Mark Gorman, November 15, 1938, Santa Monica.
Goodman, Emanuel, February 22, 1938, San Francisco.
Hanlon, Edward Russell, June 24, 1938, Los Angeles.
Harris, Henry, July 7 1938, San Francisco.
Hobdy, William Cott, December 26, 1938, San Francisco.
Houghton, Arthur D., January 23, 1938, San Fernando.
Hovde, Anders G., August 14, 1938, Hollywood.
Hull, James Porterfield, July 22, 1938, Stockton.
Jones, Wendell A., September 20, 1938, Riverside.
Kilbourne, Norman J., January 16, 1938, Los Angeles.
King, Joseph Millen, October 7, 1938, Los Angeles.
Lancaster, Jesse Samuel, November 5, 1938, Torrance.
Lando, Milton E., January 31, 1938, Oakland.
Langdon, Samuel W. R., December 30, 1938, Stockton.
Lepper, Lawrence E., September 18, 1938, Los Angeles.
Loehr, Bert E., April 12, 1938, San Jose.
Lopez, Ernesto A., February 1, 1938, San Leandro.
Loveren, George S., February 3, 1938, Santa Barbara.
Martin, John Perry, July 5, 1938, Oakland.
McArthur, Peter R., April 5, 1938, Los Angeles.
McClenahan, H. C., December 11, 1938, San Francisco.
Meneray, Prince Albert, March 1, 1938, Santa Rosa.
Merrill, Belle Ellingsen, July 6, 1938, Oakland.
Montgomery, John L., January 24, 1938, Mandovi, Wis.
Montgomery, Mary F., August 30, 1938, San Francisco.
Newcomb, Arthur Thurston, July 18, 1938, Pasadena.
Nichols, Fred C., May 27, 1938, Santa Monica.
O'Neill, Arthur Aloysius, March 2, 1938, San Francisco.
Orbison, Thomas James, March 26, 1938, Los Angeles.
Orr, Jane, August 19, 1938, Oakland.
Petty, Charles Odell, November 17, 1938, Fullerton.
Pierce, Sterling N., September 30, 1938, Los Angeles.
Pindler, Louis Alden, October 9, 1938, Los Angeles.
Potter, Clarence D., December 8, 1938, San Francisco.
Putnam, Victor E., March 11, 1938, San Francisco.
Rixford, Emmet, January 2, 1938, San Francisco.
Russell, William Wallace, March 2, 1938, San Diego.
Schwarz, Theodore E., August 4, 1938, Oakland.
Simmons, Gustavus Crocker, August 8, 1938, Inverness.
Scribner, Richard G., November 19, 1938, Sacramento.
Sloan, Orville Joseph, April 30, 1938, Glendale.
Smith, Frank Holmes, February 19, 1938, San Bruno.
Spiegel, Maurice J., April 21, 1938, Los Angeles.
Sundin, Peter O., November 29, 1938, Los Angeles.
Swindt, Joseph Martin, June 9, 1938, Pomona.
Taltavall, William A., December 22, 1938, Redlands.
Tobin, Peter Arthur, November 21, 1938, San Francisco.
Upshaw, Harry Thomas, August 11, 1938, Pasadena.
Van Vorhis, James H., February 9, 1938, Corcoran.
Vecki, Victor G., November 16, 1938, San Francisco.
Veon, John E., January 12, 1938, Bakersfield.
Weirich, Elmer W., November 20, 1938, Angels Camp.
Whitelock, Thomas S., May 25, 1938, San Diego.
Wickman, Herman John, September 29, 1938, Riverside.
Widney, Joseph P., July 4, 1938, Los Angeles.
Wiese, Walter Fred, January 29, 1938, Fresno.

COMMITTEE ON HOSPITALS, DISPENSARIES, AND CLINICS

Executive Group

W. E. Mitchell, Chairman, 1939
Karl L. Schaupp, 1940 George Dawson, 1941

To the President and the House of Delegates:

The Committee on Hospitals, Dispensaries, and Clinics has not met during the past year. Therefore, no problems have been referred to this committee.

Respectfully submitted,
W. E. Mitchell, *Chairman.*

COMMITTEE ON INDUSTRIAL PRACTICE

Executive Group

Philip Stephens, Chairman, 1939
Harry E. Zaiser, 1940 Morton R. Gibbons, 1941

To the President and the House of Delegates:

Little has transpired officially or unofficially in connection with the above committee which would be of sufficient interest to embody in a formal report.

Inasmuch as there has been a change in the State Administration, there are many rumors as to certain action or actions to be taken by the Administration in regard to our State Compensation Insurance Act. However, there is nothing of sufficient authenticity to record. One of the most favorable rumors to be mentioned is that the present Administration has signified a sincere desire to make a broader and more equitable distribution of the State industrial fund work than was allegedly made by the previous Administration. No doubt, there will be some attempt made by legislative enactment to change features of the act, but none as yet has come to our notice of sufficient importance to record. There is still a growing tendency on the part of large groups, especially the metropolitan districts, to get a large majority of the accidental insurance work in industry and a marked lessening in the number of cases distributed to individual surgeons amply fitted professionally to give full care to this type of minor and major surgery. From the standpoint of the insurance carrier it might be stated that one reason for this condition is due either to the inability, inexperience or negligence on the part of the individual doctors to render proper, sufficient and understandable reports so necessary to conduct the lay activity of the carriers' business that there is a tendency on the part of these carriers to send work to the larger groups who have ample clerical force and enterprise to make these objections rare and almost unknown. It would seem to us that certain information, educational in character, should be disseminated either locally or by the State educational group, which would be of considerable value to the younger or older men who desire to do this particular class of work, especially those located in the metropolitan and industrial communities.

Respectfully submitted,
Philip Stephens, *Chairman.*

COMMITTEE ON MEDICAL DEFENSE

Executive Group

George G. Reinle, Chairman, 1938
Fred R. De Lappe, 1939 John P. Nuttall, 1940

To the President and the House of Delegates:

Medical defense (malpractice defense) is a subject of increasing interest to all physicians, because, during the past twenty-five years, members of the medical profession have presumably been selected as a group from whom money, under threat of scandalous publicity, might be more or less easily extracted. So numerous have been such onslaughts in the courts, and so susceptible to specious arguments have so many juries shown themselves to be, as evidenced in heavy verdicts for plaintiff patients, that several casualty and insurance companies, who formerly operated in California, have entirely withdrawn from the state. For the same reason, the premium rates of the remaining companies have not only been greatly increased, but the amount of coverage indemnity has been considerably lessened.

It is true that part of this may be due to the psychology of the times—the desire on the part of many persons to try to get "easy money," that is, money without working for it; but, in addition, another factor is the type of patient enumerated above, with an indiscreet physician, who consciously or unconsciously had spoken out of turn in unnecessary disparagement of a colleague, in combination with an attorney-at-law willing, on a contingent basis, to enter suit, if costs were covered. These, as in many past malpractice cases that have occupied the time of courts, all continue to operate.

Which emphasizes the merit of the plan in vogue in some of the New England, and also some of the Pacific states, that in any case of a threatened malpractice suit, a special committee of physicians calls before it all physicians who have seen the patient making the complaint, and all physicians whose testimony was apt to be called for in court; a possible instrument of great value to members, both of the legal and medical professions. Your Committee on Medical Defense is making a study of these plans, and hopes in due time to present the same to the State Association Council, and with its permission, to the County Medical Societies. It may be taken for granted that the malpractice problem is one worthy of earnest attention, and if a plan could be put into operation whereby malpractice suits would be reduced in number, and the insurance coverage costs also lessened, then such an effort should be made.

Respectfully submitted,
George G. Reinle, *Chairman.*

COMMITTEE ON MEDICAL ECONOMICS

Executive Group

John H. Graves, Chairman, 1941
Edward M. Pallette, 1940 William R. Molony, Sr., 1939

To the President and the House of Delegates:

The usual activity during the past year in regard to health insurance has brought a large volume of problems before this committee for study and analysis.

Suggestions and conclusions of the committee are from time to time submitted for consideration to the Public Relations Committee.

A written report was submitted at the Conference of Standing Committees and County Secretaries at their meeting in San Francisco on February 27, 1939.

Respectfully submitted,
John H. Graves, *Chairman.*

COMMITTEE ON MEDICAL EDUCATION AND MEDICAL INSTITUTIONS

Executive Group

Loren R. Chandler, Chairman, 1939
John B. Doyle, 1940 B. O. Raulston, 1938

To the President and the House of Delegates:

Your Committee on Medical Education and Medical Institutions has coöperated with the four medical schools in California and, with your Committee on Postgraduate Education, has considered matters referred to it by the Association, appointing a subcommittee on tuberculosis to make a study of the facilities in this State for the treatment of tuberculosis and other pulmonary diseases, and to coöperate with all existing agencies for the improvement of necessary conditions.

Your committee sees no need to report on the work of each medical school in California, as their activities are described adequately from time to time in bulletins and reports.

Respectfully submitted,
L. R. Chandler, *Chairman.*

COMMITTEE ON MEMBERSHIP AND ORGANIZATION

Executive Group

George D. Maner, Chairman, 1941
G. Dan Delprat, 1940 Dewey R. Powell, 1939
The Secretary, ex-officio

To the President and the House of Delegates:

The Committee on Membership and Organization of the California Medical Association held no formal meetings during the year.

The efficiency of the component county association organizations, together with specific campaigns for membership in some of the county units, necessarily preclude the activities and functions of this committee.

The responsibilities of seeing that all eligible physicians are informed as to the advantages of membership is in the hands of the various component county units.

Recent resolutions adopted by the House of Delegates of the American Medical Association relative to accredited hospitals permitting only members of component societies on their staffs has created a problem for admission committees, especially in some of the metropolitan centers, in that many undesirable physicians now are applying for membership so that they will be able to be listed as staff members of accredited hospitals.

The total membership of the California Medical Association as of January 1 was 6,077, as compared with 5,867 in 1937. The number of deaths was 78; a net gain in membership of 132.

The total number of physicians in the State in 1938 was 9,785; thus, there are 3,698 physicians who are nonmembers at present.

An analysis shows that of those nonmembers about 5 or 6 per cent have been former members who have been dropped for nonpayment of dues or other causes, and that about 15 per cent are physicians fifty-five years of age or older who in the past have never been desirous of associating with organized medicine and thus are a questionable value at the present time.

The survey also shows that about 10 per cent of the nonmembers fall in the advertising or quack classification and are not eligible. About 2 per cent are independents or malcontents and would not join under any conditions.

At present it is estimated that of the 3,698 nonmembers only about 1,500 or thereabouts should be considered as desirable.

As the necessity arises your committee stands ready to initiate and carry through such plans and programs as are deemed best and wisest.

It is the opinion of your committee that any plans proposed for intensive membership drives by county units should be considered carefully and thoughtfully by their governing bodies and the question of eligibility should be investigated carefully before election. However, all county society secretaries should inform desirable nonmembers as to the advantages of becoming members of their county societies.

Respectfully submitted,
George D. Maner, *Chairman.*

COMMITTEE ON POSTGRADUATE ACTIVITIES

Executive Group

John C. Ruddock, Chairman, 1940
F. E. Clough, 1941 F. F. Gundrum, 1939
The Secretary, ex-officio

To the President and the House of Delegates:

The Committee on Postgraduate Activities has had several meetings during the past year. The committee has carried on extensive correspondence between the office of the Association, among themselves, and with various committees and units throughout the State.

The committee feels that the precedent, which has been established by the publication of a five-year study program for graduates in medicine, is very worth while and the changes which have appeared in the last issue, called Supplement Number Two, have been caused by the experience of its application for the past year, as well as by recommendations from various specialized units throughout the State. The subjects as listed in the Supplement are not intended for didactic work in medicine. They are not designed to provide physicians for any specialty, but they are intended to afford to units and localities an opportunity to form a program, and to obtain speakers, so that the members of that locality may remain abreast of scientific programs and apply what they gain in their daily practice with an understanding of the underlying problems and fundamentals.

The Council of the California Medical Association has recognized the fact that organized medicine has an obligation to fulfill, and has promptly carried out the recommendations of the committee in order to afford an opportunity to its membership to engage in continuous educational study with a minimum of inconvenience, time and expense.

It has been stressed, from time to time, that the California Medical Association is not running a postgraduate school. However, the Association, through its executive offices at 450 Sutter Street, San Francisco, will list and attempt to make available to the membership, in various communities throughout the State, opportunities for postgraduate conferences and study. The details of the conferences in the localities must, of necessity, be left to the local committee. It is not the purpose of the committee to assign speakers. However, the committee, after circulation of numerous questionnaires during the past year, has accumulated the names of men who are available to localities for certain of the specified courses as listed in the Supplement. These names will be furnished the local committees in order to assist them to invite the speakers. This committee wishes to stress that they would desire the local committee to issue its own invitations to the speakers, asking them to conform, as closely as possible, to the outline in the prescribed curriculum as noted in the Supplement to California and Western Medicine.

Due to the large geographical extent of the State of California, with its mountains which divide the State into such definite areas, the committee feels that for certain northern areas teams should be made up, and dates so arranged, that a number of conferences can be given by one team in one circuit. Traveling in certain areas must be by auto and, therefore, conferences can only be arranged during certain seasons of the year.

It is extremely gratifying to the committee to find such widespread response in answer to its questionnaires for participation in these postgraduate conferences.

There has been a prompt response and coöperation by the four medical schools in this state, as well as excellent response by various organized commissions and allied medical and social groups.

The committee has been unable, as yet, to work out a satisfactory program with the California State Board of Health whereby the use of Social Security funds can be utilized in financing that part of the program which deals with child and maternal welfare. Recently, a program was devised whereby the various child and maternal welfare programs have been designated, but these are entirely under the sponsorship of the Board of Health, and our participation is only in assisting in the program. It is hoped that further participation in postgraduate study under the Social Security funds available to this state can be attained. The California Medical Association has the machinery, it has the program, it has the men who desire the training, and the Association is anxious to place this program into effect. The legal restrictions that have been placed around the

Social Security funds have prevented, until this time, a full participation in it.

It is hoped that the work of this Committee, which has now been started and is now on a definite basis, will be continued. The Committee has felt that clinical rather than didactic lectures are the programs of choice for postgraduate conferences. The Committee realizes that there are certain members of the California Medical Association who will not embrace the opportunities for postgraduate conferences which are offered to them. However, the opportunities will be available, and if they are not taken advantage of, then those men will lose who do not embrace them.

The Committee wishes at this time to thank the Council of the California Medical Association, the committees and such allied organizations and sections who have assisted them in the preparation of the supplement, and the membership at large for the interest they have taken in postgraduate activities.

Respectfully submitted,
John C. Ruddock, *Chairman.*

COMMITTEE ON PUBLICATIONS

Executive Group

Ralph Eusden, Chairman, 1940
Ruggles A. Cushman, 1941 Oscar Reiss, 1939
The Editor, ex-officio The Secretary, ex-officio

To the President and the House of Delegates:

The report of the Editor of California and Western Medicine is to be considered in connection with this Committee's report.

The Publications Committee recommends as worthy of notice the editorial policy, the physical arrangement of contents, and the contents itself of the official organ, and commends the Editor on the fact of this Journal's high standards.

We are now in the midst of changing social and economic conditions and, just as throughout time medicine has adapted itself to social changes, we shall again adjust to the changing social customs and aspirations.

Of necessity, editorial comment and publication of articles pertinent to the Medical Association's position in this economic-political situation have been provided, to the end that our membership may be well and honestly advised.

Too long our light has been under a bushel, and we are now placed in the position of taking the offensive. Let this be increasingly emphasized.

Our Journal continues to hold an outstanding position in the field of state and regional journals.

This being a legislative year for the state, the Committee urges that you thoroughly read your Journal for initiative guidance.

As stated in a previous committee report, the policy of the Editor in publishing State Association, convention papers and original papers, and giving preference to clinical presentations, has been maintained. When, because of the manifold number of papers, some, of sheer necessity, could not be published, effort has been made to get publication in corresponding journals.

The Committee recommends the whole-hearted support of the Council and House of Delegates to the present and projected character and policy of California and Western Medicine.

The Committee further wishes to express complete confidence in and respect for the Editor of California and Western Medicine, and to bid him godspeed in going forward.

Respectfully submitted,
Ralph B. Eusden, *Chairman.*

COMMITTEE ON PUBLIC POLICY AND LEGISLATION

Executive Group

Junius B. Harris, Chairman, 1941
E. T. Remmen, 1940 The President-elect, ex officio
The President, ex officio T. Henshaw Kelly, 1939

To the President and the House of Delegates:

The California Legislature is now in session. A progress report was made at the Conference of County Society Secretaries on February 25. At the annual session at Del Monte, further report will be made. Members who desire information concerning pending legislation will find comments thereon in California and Western Medicine, March, 1939, on page 213. Proposed legislation having relation to medical practice and public health standards, as presented this year, if anything, is of a more serious nature than usual. The alert interest of all members of the Association is urged.

Respectfully submitted,
Junius B. Harris, *Chairman.*

COMMITTEE ON PUBLIC RELATIONS

The Committee on Public Relations consists of the chairmen of the following standing committees and of certain general officers of the Association, all serving ex officio. The chairman of the committee is George G. Reinle, the secretary is George H. Kress. The director of the Department of Public Relations is George H. Kress. The chairman of the Committee on Public Relations is ex officio a member of the Council.

Fred B. Clarke, Chairman, Committee on Health and Public Instruction.
W. Earl Mitchell, Chairman, Committee on Hospitals, Dispensaries, Clinics.
Philip Stephens, Chairman, Committee on Industrial Practice.
George G. Reinle, Chairman, Committee on Medical Defense.
George D. Maner, Chairman, Committee on Membership and Organization.
John H. Graves, Chairman, Committee on Medical Economics.
Junius B. Harris, Chairman, Committee on Public Policy and Legislation.
Alson R. Kilgore, Chairman, Cancer Commission.
John C. Ruddock, Chairman, Committee on Postgraduate Activities.
William W. Roblee, President of California Medical Association.
Charles A. Dukes, President-elect.
George H. Kress, Secretary-Treasurer.

Communications for the Public Relations Department should be addressed to the Director, George H. Kress, M. D., Room 2004, 450 Sutter Street, San Francisco.

To the President and the House of Delegates:

During the last year the problems confronting the medical profession in California were of a special and important nature, such as the State Humane Pound Act and plans for medical service on a periodic payment basis, these demanding attention not only from one, but from several committees and groups, as well as of the Council.

As regards the first measure, Proposition No. 2, which was presented to the voters as an initiative proposition on the November, 1938, ballot, the Director of the Department of Public Relations sent out literature from the Central Office of the Association, to all County Societies and their members, outlining plans of procedure whereby all agencies friendly to medical research, were brought into the battle against that proposed law, which went down to deserved defeat.

The Chairman and Secretary of the Committee, with President-elect Dukes, attended the second annual session of the Pacific States Medical Executives Conference in Portland. The exchange of views by representatives from the various Pacific states was most profitable to all who were in attendance. Of particular interest were the discussions on malpractice defense procedures. The Committee had as its representative at the special session of the American Medical Association House of Delegates in Chicago, President W. W. Roblee.

Owing to the heavy drain on the Association's finances, only one regularly called special meeting was held, pending matters being decided in good part through exchange of views by letters.

This Committee can fill an important need, and during the coming year, renewed effort will be made to have it function in line with original plan.

Respectfully submitted,
George G. Reinle, *Chairman.*

COMMITTEE ON SCIENTIFIC WORK

Executive Group

George H. Kress, Chairman ex officio
Lemuel P. Adams, 1940 F. M. Pottenger, 1939
J. Homer Woolsey, 1938
William H. Barrow, (Section on Medicine)
Ray B. McCarty, (Section on Surgery)

To the President and the House of Delegates:

The schedules for the twelve scientific sections of the California Medical Association, as given in this annual session program of the Pre-Convention Bulletin Supplement to the April issue of California and Western Medicine, represent the joint efforts of the State Committee on Scientific Work and the Section Secretaries, and it is the hope of those who have played a part in arranging for the section activities that what has been planned will be carried through in a manner in every way acceptable and pleasing to members in attendance.

Hence, the committee will appreciate criticisms or suggestions for betterment; for successful annual sessions hinge, in a large measure, on attention to even minor details. Memoranda or suggestions for changes may be left with the registration clerks or Association secretary, or mailed to the Central Office, 450 Sutter Building, San Francisco.

Respectfully submitted,
George H. Kress, *Chairman.*

CANCER COMMISSION

Executive Group

Charles A. Dukes, Chairman
Otto Pflueger, Secretary
Orville Meland, Secretary for Southern Section
A. Herman Zeiler Harold Brunn
Gertrude Moore Henry J. Ullmann
Clarence G. Toland

To the President and the House of Delegates:

The Cancer Commission is primarily interested in professional education. During the past few months we have been active in furthering professional education along two lines:

(*a*) Postgraduate. A short time ago each member received a supplement to California and Western Medicine, prepared by Doctor Ruddock and his committee. In this brochure, wherein are listed a number of topics, are a number relating to cancer. We have submitted names of qualified men to appear on the programs dealing with malignant conditions. It is proposed to send out teams of three men, comprised of a clinician, a pathologist, and a radiologist, to conduct a half-day meeting. They will hold clinics, present slides, and discuss the clinical course, diagnosis, and treatment pertaining to the particular subject under discussion.

(*b*) Creation of a new section at the conference held on the Sunday before the annual meeting of the State Association. Heretofore, the Commission has sponsored the pathologic and radiologic conferences, at which specialists in these divisions have taken part. It is now proposed to have a section for the general men and surgeons. It is hoped that fifty men will register and bring their microscopes. At this meeting the pathology will be presented and explained, with comments on treatment by a surgeon and radiologist.

(*c*) Pathology and radiology meetings were sponsored by the Commission at the State meeting in Pasadena and also a mid-winter conference on pathology in Los Angeles in December. All of these were very well attended.

At the present time the Commission is undertaking a survey of the cancer clinics throughout the state, and letters have been sent to all the county secretaries asking them to forward to us a list of all the cancer clinics established in each county. This is being undertaken with the idea of lending approval to such clinics as warrant it, depending upon their standards of operation.

In order to reach younger men in the medical schools, on approval of the Council, a copy of the report of the Cancer Commission studies has been sent to each senior and junior student in all the medical schools in the state, as well as to the house staffs of the large hospitals.

Lay education, though looked upon as a vital phase of the cancer program, has been carried out only indirectly, in that members of the Commission have acted in an executive capacity for the Women's Field Army campaign of the American Society for the Control of Cancer. During this last fall it was suggested that the Woman's Auxiliary to the State Association take part in this work, and with the approval of the Council this was done. The success of this plan remains to be seen. We frequently see patients visiting physicians earlier as a result of this campaign.

Respectfully submitted,
Alson R. Kilgore, *Chairman.*

V

REPORTS OF SPECIAL AND COUNCIL COMMITTEES

COMMITTEE ON MEDICAL RESEARCH

Executive Group

Philip K. Gilman, Chairman
Loren R. Chandler Charles A. Dukes

To the President and the House of Delegates:

Your Committee on Medical Research is pleased to report defeat at the hands of the voters of California of the so-called "State Humane Pound Law" at the election in November last.

Since the election, your committee as a whole has been less active.

Following the decisive defeat of the antivivisection pound act, the members of your committee and many members of the California Society for the Promotion of Medical Research felt that the time had arrived when a real humane pound bill should be introduced at the present session of the Legislature at Sacramento.

Your chairman has, at the request of the Council of the California Medical Association, coöperated in drawing up such a bill for introduction by our Legislative Committee.

Respectfully submitted,
P. K. Gilman, *Chairman.*

COMMITTEE ON LOCAL ARRANGEMENTS: ANNUAL SESSION AT DEL MONTE, MAY 1-4, 1939

Executive Group

Mast Wolfson, Chairman
Alfred L. Phillips Curtis B. Gorham
W. M. Gratiot H. R. Lusignan
Association Secretary ex-officio

To the President and the House of Delegates:

Several meetings have taken place with both the local and the central committee members. Plans are well in hand and things are shaping up so that members may enjoy themselves to the fullest extent in many diversified fields. Entertainment will be organized, from dancing to golf, fishing, trap shooting, etc., so bring the necessary equipment to suit your particular need. We hope to make this a great and enjoyable meeting.

Respectfully submitted,
Mast Wolfsohn, *Chairman.*

COMMITTEE ON HOSPITALS

Executive Group

Louis A. Packard, Chairman
Axcel E. Anderson Calvert L. Emmons

To the President and the House of Delegates:

Your Committee on Hospitals has been active throughout the past year. Continued study of the county hospitals and the problems associated with them have been carefully reviewed.

The most important accomplishment, we feel, is the relationship established between the California Medical Association and the Farm Bureau Federation and allied groups. Bitter opponents in the past, these groups, through round-table conferences, have ironed out their difficulties and in so doing come to the conclusion that both groups were trying to arrive at the same destination by different paths. At this time compatibility of thought and action has been reached, and legislation was introduced by the farm group which follows the ideas developed in conferences.

It is hoped that future years will see the harmony now existing continued and extended to other fields.

Respectfully submitted,
Louis A. Packard, *Chairman.*

SUB-COMMITTEE ON PNEUMONIA CONTROL

Executive Group

Roy E. Thomas, Chairman
William P. Shepard, Secretary
Edwin L. Bruck Lambert B. Coblentz
Karl F. Meyer George D. Maner
Daniel D. Comstock

To the President and the House of Delegates:

The Committee on Pneumonia Control was authorized to function as a subcommittee of the standing Committee on Health and Public Instruction. The subcommittee in turn has been functioning through two subgroups, one for the northern, the other for the southern end of the State. We have also acted in conjunction with the California Medical Association Committee on Postgraduate Activities. A detailed report will appear in California and Western Medicine.

Respectfully submitted,
Roy E. Thomas, *Chairman.*

COMMITTEE ON SYPHILIS

Executive Group

Howard Morrow, Chairman
Charles W. Barnett William H. Goeckerman

To the President and the House of Delegates:

The venereal disease control program administered by the Bureau of Venereal Diseases, State Department of Health, has continued to expand during the past year. There has been increasing coöperation on the part of physicians in private practice and general approval of the control measures that have been adopted.

The number of cases of syphilis reported has continued to increase. This is illustrated by the following figures as provided by the State Department of Health: 1936—11,725, 1937—17,282, 1938—23,313. There has been marked expansion of clinic resources. Treatments for syphilis administered in clinics during the past three years are as follows: 1936—206,185, 1937—301,185, 1938—458,138. The number of clinic centers where treatment is available has been increased in the past two years from 70 to 110. During the past year there has been expansion of clinic facilities in Los Angeles City and the following counties: Imperial, Santa Barbara, Monterey, Santa Cruz, Fresno, Contra Costa, San Francisco, Sonoma, and to lesser degree in other counties.

Sufficient drugs for 427,611 treatments were distributed free to private physicians by the State Department of Health during 1938.

There are now twenty-four full-time health departments taking care of 81½ per cent of the population of the State. Through funds provided by the State Department of Health, twenty-one physicians received postgraduate training in venereal disease control at the Curriculum in Public Health at the University of California during the past year. Ten conferences on syphilis were held before county medical societies. Pamphlets pertaining to diagnosis and treatment of syphilis were mailed by the State Department of Health to approximately 5,000 physicians.

Public Health laboratory services have been rendered more available to physicians in private practice for tests on indigent and marginal patients. A mailing dark-field service was inaugurated by the State Laboratory.

A number of county medical societies have actively participated in local educational programs and in the development of more adequate local facilities for the control of syphilis. This committee has encouraged such activity and has coöperated in every way possible with the official agencies assigned to carry out the venereal disease control activities.

Respectfully submitted,
Howard Morrow, *Chairman.*

SPECIAL COMMITTEE ON A BASIC SCIENCE LAW

Executive Group

George H. Kress, General Chairman
Morton R. Gibbons, Chairman (for Bay Region)
Edward M. Pallette, Chairman (for Southern California)
Junius B. Harris, Chairman (for remainder of State)

To the President and the House of Delegates:

States in which multiple healing-art boards of examiners have received legal recognition must expect to witness, when their legislatures are in session, more or less constant attempts by "new" cultist groups, to secure legal sanction.

California has just such "multiple healing-art boards": (1) Board of Medical Examiners; (2) Board of Osteopathic Examiners; (3) Board of Chiropractic Examiners. Among these the Medical Board exists through legislative enactment, but the Osteopathic and Chiropractic Boards were created through initiative vote of the citizenry.

A group that has been recurrently knocking at the door of the California Legislature is that which calls itself "Naturopathic." In the present session of the California Legislature, this year's Naturopathic effort (Assembly Bill 1203) was submitted to the legislators on January 23, and a vigorous educational campaign is now being waged by the disciples to secure legal recognition.

Nonsectarian or regular medicine does not demand that a commonwealth refuse to grant recognition to sectarian practitioners of the healing art, provided that, at least, fundamental standards of preliminary education be complied with. Healing-art practice, with responsibility for the health and lives of fellow humans, demands that every licensed practitioner, no matter to what group he may belong, should have that basic education giving warrant of mental capacity to grasp the significance of changes in the diagnosis and treatment of disease and injury. It is just there that a Basic Science law is of value in the protection of the health and lives of citizens.

The essential provision of most basic science laws lies in this: that, prior to the right of any individual to take an examination for licensure by his respective board, he shall have filed with that body a certificate, showing that he has passed the examination of the Basic Science Board. The preliminary education usually demanded is at least the equivalent of a four-year high school course, plus one or two years of liberal arts work, such as are given in the freshman and sophomore years of a state university course. Certainly, that is not too much to ask, and nothing less should be accepted by a state.

Had not the State Humane Pound Act initiative thrust itself into the foreground at the November, 1938, state election, it is more than probable that an initiative petition for a Basic Science law would have been submitted to the people at that time. This subject has been repeatedly discussed in California and Western Medicine during the last ten years, and in the April, 1938 Pre-Convention

Bulletin, on page 51, is given a list of references to articles upon the theme which have appeared in the OFFICIAL JOURNAL. Members, consequently, who are interested should consult the bibliography to be found there.

The California Medical Association House of Delegates, in years gone by, have authorized the Council to proceed with a Basic Science initiative, but each time unforeseen contingencies have arisen to prevent the carrying out of these instructions.

Since the next state election will be held in November, 1940, and the preparation of an initiative law and the necessary securing of signatures is a task requiring months of thought and effort, it is suggested that the House of Delegates, at the Del Monte session in May, 1939, will indicate its wishes in this most important matter. The files of the Special Committee, to whom was delegated this study during the last ten years, will be turned over to whomsoever is placed in charge, because the plans will need much continued thought and work.

Respectfully submitted,
George H. Kress, *General Chairman.*

COMMITTEE ON CANCER EXHIBIT: GOLDEN GATE INTERNATIONAL EXPOSITION

Executive Group

T. Henshaw Kelly, Chairman
Edward M. Pallette
Charles A. Dukes
Karl F. Meyer
Hartley F. Peart

To the President and the House of Delegates:

The Council of the California Medical Association appropriated funds from the Herzstein Bequest to build and maintain an exhibit in the Hall of Science at the Golden Gate International Exposition, on cancer.

The committee, in coöperation with Mr. Milton Silverman, Director of the Hall of Science, created the exhibit to answer in the present state of our knowledge the questions, What is Cancer? How can it be discovered? What can be done for it? and, What is the probable future course of cancer research?

The committee is grateful to Mr. Silverman for his interest, help and coöperation, and the exhibit was ready when the Fair opened.

Respectfully submitted,
T. Henshaw Kelly, M.D., *Chairman.*

ADDENDUM*

MINUTES OF THE MEETING OF THE COUNTY SECRETARIES OF THE CALIFORNIA MEDICAL ASSOCIATION †

The meeting of the County Secretaries of the California Medical Association was held in the Franciscan Room of the Sir Francis Drake Hotel, February 25, 1939.

CALL TO ORDER

The meeting was called to order by Dr. Robert A. Peers, who had been designated to preside. County Secretaries present were:

Robert A. Peers	Placer County Society
M. M. Booth	Napa County Society
Lester R. Nielson	Fresno County Society
Joseph S. Woolford	Humboldt County Society
C. S. Campton	Kern County Society
Victor W. Hart	Siskiyou County Society
Hoyt R. Gant	Stanislaus County Society
Leon M. Swift	Yuba-Sutter County Society
T. E. Albers	Sonoma County Society
George D. Maner	Los Angeles County Society
E. M. Bingham	San Luis Obispo County Society
A. A. Morrison	Ventura County Society
Glenn Curtis	Orange County Society
A. E. Varden	San Bernardino County Society
Thomas A. Card	Riverside County Society
Herbert Archibald	Monterey County Society
William A. Clarke	Imperial County Society
Samuel R. Randall	Santa Cruz County Society
John W. Green	Solano County Society
Glenn E. Millar	Sacramento County Society
George H. Rohrbacher	San Joaquin County Society
Carl W. Clark	Marin County Society

Also present were:

George H. Kress	Association Secretary
Ruggles Cushman	Delegate from Mendocino County

PURPOSE OF MEETING AND QUESTIONS SUBMITTED

Doctor Peers explained that the purpose of the meeting was to afford an opportunity for the Secretaries to debate informally various questions which had been sent to Doctor Kress for discussion at this meeting. Doctor Peers stated also that it would be in order for this body to make suggestions and recommendations. The questions were taken up in the following order:

⁂

1. Question presented by Doctor Bingham of San Luis Obispo:

What is the present status concerning the A.M.A. Survey of Medical Care in the counties represented by the Secretaries present at the meeting?

The general opinion seemed to be that too great a burden had been placed on the County Secretaries, and a number of those present stated that apparently the County Society members felt the same way, as the percentage of completed returns was very small. Dr. George Maner of Los Angeles suggested that this be referred to the Council, and that the Council be requested to reaffirm its stand on this matter; that the Committee of Five had submitted this information in the form of the California Medical Economics Survey.

⁂

2. Question presented by Doctor Woolford of Humboldt:

What is the best method of publicizing and selling California Physicians' Service to the public? When are we going to present this, and how are we going to do it?

Dr. George Maner reported regarding the Questions and Answers submitted by the Trustees of the C.P.S. to the Los Angeles Medical Association for use in their Bulletin. Doctor Maner reports that these are of much value.

Doctor Maner made the suggestion that C.P.S. Questions and Answers, similar to those furnished to the Los Angeles County Medical Association, be furnished to all County Societies.

The suggestion was made that the C.P.S. Questions and Answers be printed in CALIFORNIA AND WESTERN MEDICINE.‡

⁂

3. Doctor Clarke of Imperial County, asked about Postgraduate Clinics.

Because this matter is No. 10 of Part 5 of the general program, this question was referred to the general meeting.

⁂

4. Question presented by Doctor Clarke of Imperial County:

How will the present status of the insurance plan affect smaller communities?

This matter was referred to the general meeting, as Part 2 of the program is a symposium on medical service activities.

⁂

5. Doctor Clark of Marin County, asks:

What part should the County Society play in putting over physicians' health insurance plan?

Doctor Booth stated that he felt every possible effort should be made to get the insurance plan operating in smaller communities as quickly as in San Francisco and in Los Angeles. Doctor Booth felt that our Secretaries' group should stress the importance of getting the group operating in small communities.

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* This addendum is given place in the Pre-Convention Bulletin because of the importance of the services rendered to organized medicine by the secretaries of the component county medical societies.

† Meeting was held at the mid-year Conference of Officers of the California Medical Association and of Secretaries of component County Medical Societies at the Sir Francis Drake Hotel, San Francisco, on Saturday, February 25, 1939.

‡ The questions and answers were printed in CALIFORNIA AND WESTERN MEDICINE, March, 1939, issue, on page 247.

* * *

6. Doctor Morrison of Ventura County:

In re Public Health Advisory Committee of Ventura County.

Doctor Morrison explained how, in Ventura County, a Public Health Advisory Committee had been formed, which is made up of representative members of all county organizations. The Committee has been advisory to the Board of Supervisors and has proved of great value. These county organizations consist of such groups as P.-T.A., Women's Luncheon Clubs, Chambers of Commerce, Service Clubs, etc. Doctor Morrison is Chairman of the Educational Committee. He feels that great good has resulted from the activities of this Public Health Advisory Committee, and that this work could be duplicated to advantage in other small communities.

* * *

7. Questions presented by Doctor Booth of Napa County:

Regarding the mileage charges of general practitioners outside of small towns? Regarding question of fees for x-ray services?

These matters were referred to the general session.

* * *

8. Question presented by Doctor Swift of Yuba-Sutter County:

Regarding C.M.A. Insurance Plan: How are they to be brought before the people, and how is the plan going to be sold?

Doctor Swift stated that in his district, three or four private insurance agencies are selling health and hospital insurance through that field, and it is about all worked, and we are wondering how this Association insurance is going to be worked out in this community?

County Secretaries refer this to the General Session for discussion.

* * *

9. Question presented by Doctor Peers of Placer County:

Proposed Amendment to Constitution, which would provide for life membership in California Medical Association, upon payment of a stipulated fee after a membership of twenty years.

Doctor Peers explained that, as men become advanced in years, with steadily-decreasing incomes, it not infrequently becomes difficult to meet the annual dues. Doctor Peers felt that if there were an amendment to the Constitution whereby it would be possible to secure life membership after a certain age by the payment of a stipulated fee, much embarrassment could be saved these older practitioners. Doctor Peers suggested the age of sixty. In order to safeguard the plan, he suggested that only those members who had been active members for twenty consecutive years could be eligible, and then only when endorsed for life membership by their County Societies. This provoked considerable discussion, all of which was favorable; the only difference of opinion being as to details, such as the age-limit or the amount of the stipulated fee. It was moved by Doctor Curtis of Orange County, and seconded by Doctor Card of Riverside County, that the Secretaries suggest that the Council appoint a committee to study such an amendment to the Constitution, whereby, upon the payment of $100, after a membership of twenty years in the California Medical Association and upon reaching the age of sixty years, a member may be made a life member of the California Medical Association. Motion carried. Doctor Hart of Siskiyou, suggested that a member who has had a membership in the California Medical Association for twenty years, upon reaching the age of seventy-five, be automatically made a life member of the California Medical Association, without the payment of additional dues or assessments.

* * *

10. Question presented by Doctor Peers of Placer County:

Discussion of health studies of educational institutions, such as high schools, junior colleges, by members of the County Medical Societies.

In explanation, Doctor Peers read a letter from the Principal of the Placer Union High School and of the Placer Junior College, asking for a survey by the County Medical Society and for suggestions as to how best these institutions could handle their public-health problems. After discussion, Doctor Card suggested that the following recommendation be made to the Council:

"It is the sense of the Secretaries of the County Societies that some unified action or course be prescribed, whereby the medical societies could be of definite help in these problems of school examinations."

There was discussion by Doctors Maner, Nielson, Green, and Doctor Card, after which Doctor Card made the motion, which was seconded by Doctor Varden. Motion carried.

* * *

11. Question presented by Doctor Green of Solano County:

Can some measure be designated whereby a doctor may file a suit in reply to the damages to his personal reputation after a malpractice suit has been filed against him?

Referred to General Session.

* * *

12. Presented by Doctor Green of Solano County:

Suggested that perhaps, through the operation of the C.P.S., many patients would ultimately seek city doctors and city hospitals rather than those in their own territories.

Referred to the General Session, the Council and, by suggestion of Doctor Kress, to the California Physicians' Service.

* * *

13. Question presented by Doctor Packard, Councilor for the Third District:

Question was regarding special license plates for automobiles of Doctors of Medicine.

It was stated that some time ago the Council dismissed a plan to ask for a special auto license plate for M.D.'s. On inquiry, it is found that in many of the smaller cities, local laws concerning parking, etc., are set aside for M.D.'s, if they have a distinguishing plate or mark on their car. This is of distinct advantage in many places. Many members of component societies might favor this, if it were brought to their attention.

The motion was made by Doctor Woolford of Humboldt County, as follows:

It is the feeling of the secretaries of component county societies that if an emblem be put on cars it be the official emblem of the American Medical Association. Motion seconded by Doctor Nielson of Fresno County, and carried.

* * *

14. Doctor Kress suggested that the Secretaries hold a follow-up or supplementary meeting to this conference, say of one or two hours' duration on the Sunday afternoon preceding the annual session in Del Monte. He stated he would send out blanks and get the reaction of the Secretaries regarding this proposed meeting.

* * *

15. Doctor Maner of Los Angeles, asks that the major topic for the meeting, if held, be concerned with scientific programs in county societies.

ADJOURNMENT

The meeting was adjourned at 10:35 a. m.

Respectfully submitted,
Robert A. Peers, *Chairman.*

HISTORIC POINTS OF INTEREST OF MONTEREY, CAPITAL OF OLD CALIFORNIA

Monterey, romantic capital of old California from 1776 to the end of 1849—and de facto from 1770 to 1776—was the political and social center of the vast empire of Spain and of Mexico that stretched from the Rockies to the Pacific and from the Oregon line to the Rio Grande and the Gila.

Though many interesting buildings from Colonial days have disappeared, more have survived than in any other city in the Far West—a half-hundred, many surrounded by their old gardens. Thus Old Monterey "where America began in the West" takes on the aspect of a national monument.

The following places are directly on the route indicated on map. (Copies of map may be secured at the Hotel Del Monte desk):

1. *Royal Presidio Chapel* of San Carlos de Borromeo de Monterey. Founded on June 3, 1770, to become the Mission church at the port, it became instead the church for the Spanish colonists and soldiers. The present Presidio Chapel was dedicated in 1795. It has been in continuous use since that date and is the only Presidio Church in California to survive.

2. *Casa Madariaga.* Originally a simple adobe of the Mexican era.

3. *Casa Pacheco.* Built in the 1840's. Restored in 1929.

4. *Casa Abrego.* Built in the 1840's by Don José Abrego, it was noted for its hospitality. Restored and owned by a well-known artist.

5. *Site of Washington Hotel.* First hotel in California.

6. *Robert Louis Stevenson House.* Old "French Hotel," where Robert Louis Stevenson spent the fall months of 1879 in a room on the second floor, facing west. Wrote "Vendetta of the West," essay on "Thoreau," blocked out "Amateur Emigrant" and "Prince Otto" in the old house. Descended the stairs on the west side to take his dinners with Jules Simoneau, the old French philosopher, who was also a famous cook. His restaurant was made world-famous by Robert Louis Stevenson through his gratitude to his kindly benefactor. Only remaining house in the West occupied by Robert Louis Stevenson.

7. *Site of "El Cuartel."* First American Capitol west of the Rocky Mountains. In part now occupied by the Chamber of Commerce building.

8. *Site of Simoneau's Restaurant.* A favorite spot of Robert Louis Stevenson.

9. *Headquarters of General José Castro.* See marker, which also indicates position of

10. *The Bull and Bear Pit* of old Spanish and Mexican days.

11. *Cooper House.* Built by Don Juan Bautista Cooper for his bride, Dona Encarnacion Vallejo, it comes down from the early Mexican period. Don Juan was one of the first Yankee skippers to settle in Monterey.

12. *Casa Amesti.* One of the finest examples of Old Monterey domestic architecture. Built in the early '30's by Don José Amesti for his daughter as a wedding gift when she became the bride of James McKinley.

13. *Casa De la Torre.* (Adobe Gift and Book Shop) the "Green Adobe." It was the home and court of Alcalde José Joaquin de la Torre, who held office when the Americans captured the Old Capitol.

14. *Stokes House* is one of the distinguished old adobes of the brave, gay days when California was young. Built in the '30's by Doctor Stokes. Many famous balls were held in its large sola, mostly cascaron bailes.

15. *The Gutierrez* adobes, diagonally across the street, adorn Main Street (Calle Principal in the days before the Gringo came).

16. *The "House of Four Winds"* derived its name from the weather vane on its roof. Built by Thomas Oliver Larkin. The adobe is said to have served the early American administration as a hall of records. Restored and owned by the Women's Civic Club.

17. *Sherman Quarters,* where General William Tecumseh Sherman lived while serving Colonel Richard D. Mason, military governor of California, as adjutant-general. General Henry W. H. Halleck occupied a log cabin near by.

18. *The Larkin House* was built in 1835 by Thomas Oliver Larkin for his residence and his merchandise store, the entrance to the latter on Jefferson Street. From 1842 to 1844 the picturesque adobe was the American consulate, its owner the only consul from the United States to Mexico. The house was the rendezvous for all English-speaking foreigners, particularly Americans, from the late '30's and the scene of notable hospitality. The house is now owned and occupied by a granddaughter of the astute American consul. The gardens, surrounded by a characteristic tile-topped stone wall, are enchanting.

19. *Colton Hall* was ready for occupancy in the spring of '49, having been built by the Rev. Walter Colton, Yankee alcalde, from the proceeds of fines of gamblers and wine-bibbers, together with the proceeds of sales of town lots. It was designed for a meeting-place (upper floor) and for school purposes. Here it was that the First Constitution of California was written—September to October, 1849. Recent research, however, has proved that it was not the first American Capitol of California. El Cuartel, torn down in the late '80's, had that honor.

The old Monterey calaboose adjoins the "Constitution Hall" (1854). Many impromptu hangings took place here without "benefit of clergy" or consent of the law, notably that of Anastasio Garcia, a famous "bad man."

20. *Brown-Underwood Adobe.* See marker.

21. *Casa Vasquez.* Home of a sister of Tiburcio Vasquez, Monterey's own bandit. Originally a one-story adobe.

22. *Gordon House.* Built in early 1850's of milled lumber brought from Australia.

23. *Casa de la Torre.* Built for Don José Joaquin de la Torre, alcalde of the Old Capital.

24. *Casa Serrano* was built by Don Florencio Serrano, alcalde under the Mexican régime. Still owned by the Serrano family. (Now Cademartori's.)

25. *Merritt House* in a large formal garden (next to church). Built by Judge Merritt in the '60's.

26. *Casa Soberanes, "House of the Blue Gate,"* is easily identified. It was built in the early Mexican regime by Don Felicano Soberanes, who married one of the beautiful daughters of Don Ignacio Vallejo. Restored by present owner.

27. *Henry House,* where Miss Lou Henry became the bride of young Herbert Hoover.

28. *California's "First Theatre."* Built by Jack Swan (who came to Monterey in 1843) for a lodging house and saloon for sailors like himself; the adobe has experienced a variety of scenes—resort for whalers, a saloon, and the first building in California where an admittance charge was made for a theatrical performance. The first troupers were made up of members of Stevenson's New York Regiment while garrisoned in Monterey in 1848. Owned by the State of California and administered by the State Park Commission. Open from 1 to 5. Free.

29. *Casa de Oro* (House of Gold). Adobe where miners during the gold-rush days used to leave their pokes for safekeeping.

30. *Casa Verde.* where Charles Warren Stoddard wrote many of his California stories and poems. He passed his last days in the Parshley house on Larkin Street, between Franklin and Scott. His grave is in the old Monterey cemetery on El Estero.

The New York Academy of Medicine

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